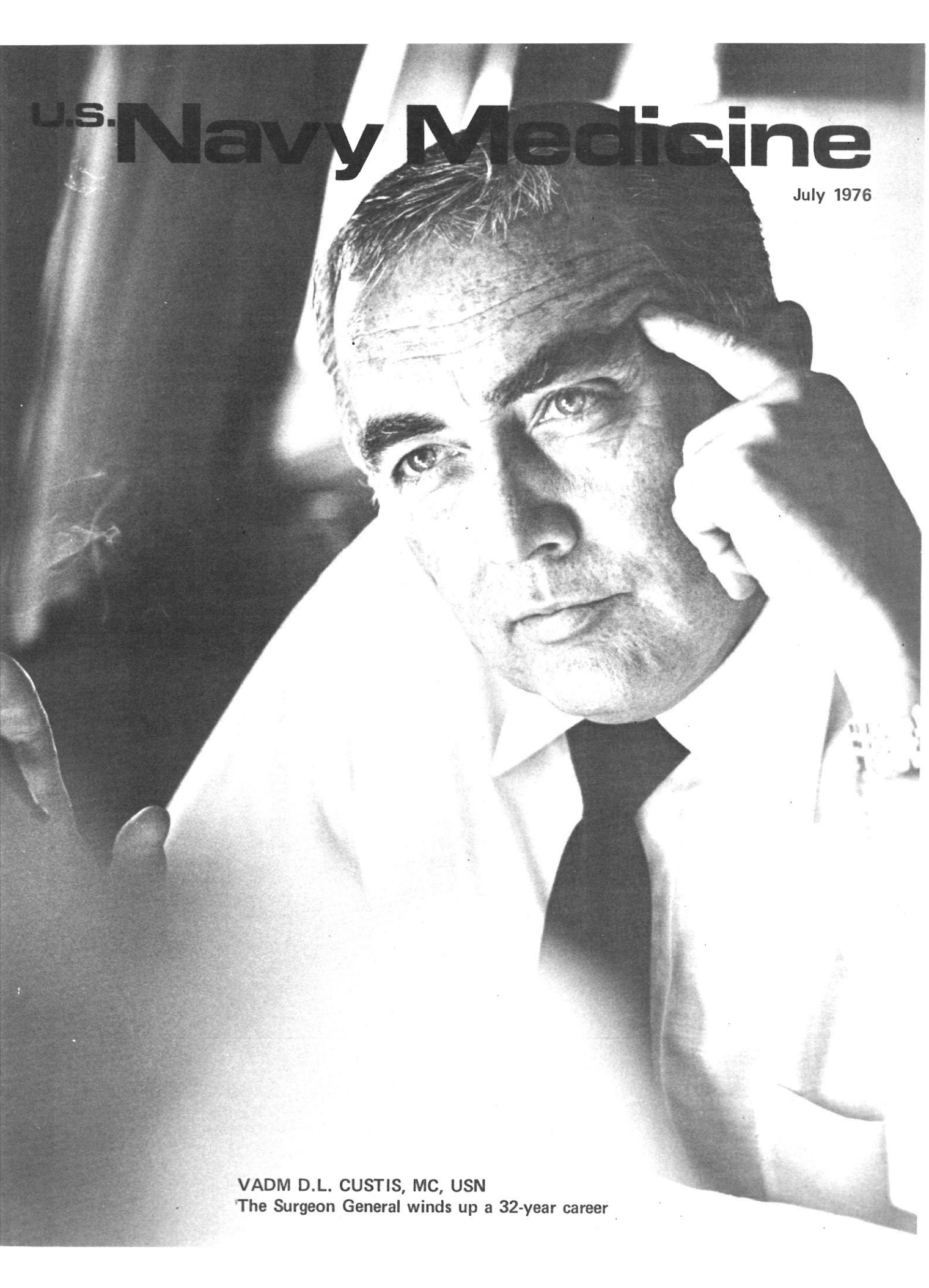


U.S. Navy Medicine

July 1976



VADM D.L. CUSTIS, MC, USN
The Surgeon General winds up a 32-year career

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Surgeon General of the Navy

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Now Hear This!



As my last "From the Chief," I have chosen to present my remarks to the June 1976 graduating class of the Naval School of Health Care Administration. I believe these remarks reflect the genuine concern of America's health care professionals; certainly they reflect the major truth I have learned during my three-and-a-half-year tour of duty as Surgeon General of the Navy.

I leave tremendously proud of all of our people in the five great corps of Navy medicine. Your magnificent performance under the adversities of these years has reflected your mettle, talent and dedication. For my part, I have learned anew the elusiveness of goals and that the struggle for their accomplishment never ends. As an idealist, I wish I could have done more; as a realist, it is enough to have had a part in the effort.

I am privileged to have for the third successive year this opportunity to present the graduation address for this, the 37th class of the Naval School of Health Care Administration. Because of my admiration for this faculty and their graduates, it is fitting that this be my last speaking engagement before retirement as Surgeon General—an occasion symbolic of passing the torch.

I join your faculty and your families in extending congratulations on your achievement. Your studies this year were superimposed upon your own practical health care experience—derived from over 13 years class average length of service. Eighty percent of you have also completed the requirements for bachelor's degrees—a record in the annals of this school. You are clearly ready for deeper and broader responsibility in a fascinating and rewarding career field. Your opportunities in the health care delivery industry are coupled with the continued satisfaction derived from service to your country.

In your administrative work, as fellow health professionals, you will be closely associated with physicians and dentists. Before your careers have run their course, however, you may find there are other professionals who may have more influence than you or your colleagues have over what you do and how you do it. I refer to the lawyers and their associates, the government analysts and the federal regulators.

Those who have heard me before may recognize that first scratch of a broken needle. Yet from my perspective there can be no more pertinent theme to exhort you who are about to inherit the management of Navy medicine, especially in this bicentennial year.

You will find that your formal education in hospital administration is a wonderful thing. It will enable you to worry about conditions throughout the Navy Medical Department.

Military medicine does not function in a vacuum. It is a sizable element of the pluralistic health care system of this country—a totality under siege.

I wish I had the time to detail for you the full impact that extramural government analysts and rulemakers have had on military medicine during just this past year. You would recognize in almost every instance similarities to indictments being leveled on the civilian health care system. The summary effect is that we are being asked to provide more and better care for increasing numbers of patients at a time when funds and personnel to provide that care are being drastically and irrationally cut. Regulators with no appreciation of the consequences are attacking our contingency strength, our education and training programs, our recruiting and retention ability, our patient mix, and authorized medical benefits. Arbitrary budget cuts have forced us to live off our supply shelves, reduce our civilian help, defer equipment replacement, and neglect essential maintenance of facilities.

Some wag placed on my desk the other day a bumper sticker which read: "If you like what's happening to military medicine, you're going to love national health insurance." The government interference already visited on the private sector is responsible for the largest problems besetting the civilian medical care industry: overpromise, regulatory snarls, and legislated incentives for waste. The record suggests that more federal interference will not improve care nor lower costs, but only reduce quality at increased cost.

Yet the consensus remains that under national health insurance medicine will soon become the first profession to be fully regulated—that the Congress will ultimately finish what it has begun. Almost everyone in the health care industry feels that some degree of regulation, under sensible standards, could be wise and useful; yet all have a gnawing concern lest the regulatory mechanism, if not restrained, first regulate, then reorder, and finally rule. Thus far there has been little restraint. Our judiciary has passively permitted the federal legislative and especially the executive branches to step into all relations between people that are statutorily deemed "consistent with the public interest, convenience and necessity."

CRUSHING OVERREGULATION

There is hardly an industrial leader today who is not adding his voice to the alarm over the crushing overregulation by the FTC, FPC, OSHA, FEA, FDA, FAA, EPA, and countless other agencies created in the contagion of turning to government to solve all problems, real or imagined, large or small, widespread or confined. It is difficult to name an area in which the federal government does not regulate.

Even the academic professorial caste is concerned. The time was when a Congressman wanting a federal program to control dangerous tricycles, utility rates, television advertising, or the distribution of neurosurgeons could always count on a phalanx of professors to agree that the private sector had failed and federal

regulation or subsidy was necessary. But no longer. One reads now of unprecedented and growing disenchantment with federal government within the teaching community. The presidents of Harvard and Yale are publicly confessing their previous naivete in deploring the consequences of federal intervention tied to university subsidies. Harvard's President Bok is concerned that "in a few short years universities have become encumbered with a formidable body of regulations, some unnecessary and most causing needless confusion and red tape." He cites federal intervention in confidential record keeping, attempts to enforce the hiring of specific groups, application of collective bargaining regulations to faculty decisions, dictated changes in school curriculum, and simultaneous, uncoordinated attempts by several government departments to regulate the same principle.

Our founding fathers attempted to narrowly limit the powers of federal government. They did this only partly from antipathy to government control of private affairs. To be sure, such antipathy was strong at the time because of direct experience in the preceding hundred years; but an equally compelling reason for restricting the power of the federal government was the realization that the form of government they wanted—a democratic government—cannot endure if it intervenes extensively in the affairs of the people. Democratic processes—representative processes, if you prefer—simply cannot handle complex, highly technical matters satisfactorily.

A democratic government cannot design efficient automobiles, it cannot design a sound energy policy, it cannot eliminate prejudice and discrimination, it cannot manage transportation, it cannot assure the soundness of investments nor the accuracy of information about them, it cannot guarantee the effectiveness and safety of medicines, it cannot, in fact, deliver the mail. It cannot, in short, do most of the things that our government undertakes to do.

Congress, perhaps partly in recognition of its own incapacity to do all it undertakes, has come increasingly not to legislate itself, but to delegate to thousands of employees the right to make and to enforce what are, in effect, laws. In so doing, they have given birth to a monstrosity: voluminous bureaucratic regulations, rulings and interpretations that have the force of law and are not subject even to minimal standards of procedural fairness prescribed by the Administrative Procedures Act. Bureaucratic regulations are not the product of elected officials responsible to an aroused electorate. Rather, they are written, administered and enforced by agency personnel who are the permanent fixtures in our government. The power these unelected individuals have over all phases of the regulatory process is enormous; they are author, administrator, advocate, judge, jury and enforcer.

Recently Alexander Solzhenitsyn made a statement about the Russian government that is becoming too

nearly true of ours: that it dislikes any relations between individuals which it does not supervise. It is not, of course, "our government" as an entity that *wants* to supervise in this country. It has been backed into the job. In almost any relation between individuals there is some group with a special interest in supervising; the influence of these special interests in our system of government is so strong they generally get their way.

The fear of unbridled regulation is as old as the republic itself. In their Bill of Particulars written in Philadelphia, the colonists protested that their monarch "had erected a multitude of new offices, and sent here his swarms of officers to harass our people and eat out their substance." How ironic that this year we honor the convictions of our founding fathers while at the same time forsaking them.

Walter Lippman gave warning many years ago of the coming sickness of an overgoverned society when he wrote:

The essential difference between the faith that our generation has embraced and the faith that it has forsaken is to be found in what it thinks some men can do to manage the destiny of other men. The predominant teachings of this age are that there are no limits to man's capacity to govern others and that, therefore, no limitations ought to be imposed upon government. The older faith, born of long ages of suffering under man's dominion over man, was that the exercise of unlimited power by men with limited minds and self-regarding prejudices is soon oppressive, reactionary, and corrupt. The older faith taught that the very condition of progress was the limitation of power to the capacity and the virtue of rulers.

The fact that our generation seems to have sold its birthright so cheaply does not mean that the old philosophy is dead. On the contrary, it may only be that our society has to relearn an old lesson—that we may have to pass through a terrible ordeal before we find again the central truths we have forgotten. But find them we will, if only the ideas that have misled us are challenged and resisted.

GLIMMERS OF HOPE

On a more positive note, there are already some encouraging signs of resistance to a consummate regulatory autocracy. Public opinion polls indicate that the people grow increasingly antagonistic to central management of their lives. The White House appears genuinely concerned at the degree and cost of federal regulatory activities. Even Congress is beginning to doubt the realism of policies which call for further regulation. There are early, halting legislative initiatives toward deregulation. While optimism must be tempered by the recognition that some encouraging statements in the political arena may be swollen by campaign rhetoric, this movement toward deregulation is a glimmer of hope.

I have not dwelt on these problems to spread discouragement, but to describe reality. What needs to be stressed is that military, like civilian, medicine has performed well in adapting to rapidly changing technol-

ogy and providing high-quality care to a broad spectrum of demanders. What imperfections there are do not warrant a major overhaul by remote and irresponsible dilettantes.

"Now hear this!"—may that familiar alert underscore my conviction.

The charge I place on you as health care graduates transcends your fundamental mission to do your very best for the patients entrusted to your care in peace and in war. For you have additional responsibilities as informed representatives of your profession and concerned citizens of your country. Your status as active members of the military does not render you apolitical, and the political impact on medicine is here to stay. Your political role is at least twofold:

First: Cherish and exercise your voting right. In the last analysis, none of the problems I mentioned will be solved without responsible action of the electorate. The electorate is you and I. The electorate must choose as its representative in every level of government, particularly in the Congress, competent individuals who believe in this country, its economic system, and its form of government. The electorate must insist that its representatives take power back from and stop delegating legislative power to the unelected bureaucracy. The electorate must insist that hard legislative policy decisions no longer be avoided by "passing the buck" to autonomous regulators—allowing the most complex decisions to be made at the lowest technical level, by people with no experience in the fields where they regulate and no real understanding of what this nation is all about.

Second: Enlarge your perspective as a truly qualified student of health care issues. Be an effective spokesman in your own community. Be an active participant in your professional societies and associations. Lend your voice to the collective leadership of experts in health care who seek responsible answers to present problems, and representation in the design of things to come. Be a contemporary "Son of Liberty."

Whatever regulatory mechanism is needed in health care, as in all other sectors of national endeavor, must be responsive and representative, if quality and volunteerism are to prevail.

Two hundred years ago, in Old Boston, the Sons of Liberty anathematized taxation without representation. If tomorrow's health care regulators are themselves to be regulated, the maxim for today's health professional must be: "No regulation without representation."

Goodbye, good luck, and Godspeed.



Surgeon General of the Navy

Department Rounds

BUMED

VADM Custis Announces Retirement

VADM Donald L. Custis (MC), Surgeon General of the Navy, will retire from active duty on 1 August, ending a 32-year career in Navy medicine. He has held the Navy's top medical job as Surgeon General and Chief of the Bureau of Medicine and Surgery since February 1973.

Under Admiral Custis' direction the Navy Medical Department developed a streamlined health care delivery system emphasizing a team approach to patient care and cost-effective operations. His tenure will be remembered for a fistful of exceptional accomplishments crucial to the medical profession and responsive to the problems of the times:

- New commands established for Navy medical research and development, and health sciences education and training.
- A new BUMED code consolidating medical support for the operating forces.
- Regionalization of all BUMED-managed medical activities.
- Medical Service Corps and Nurse Corps officers introduced into high-level executive positions in naval medical facilities.
- Aggressive programs to recruit and retain physicians in the all volunteer force.

Admiral Custis has been a dynamic and influential spokesman for military medicine on the Washington scene—a prudent man who speaks the plain truth in a manner that commands respect. He championed the cause of the Uniformed Services University of the Health Sciences when that beleaguered institution was little more than a pipe dream. While supporting the concept of the all volunteer force, he warned that rash budget cuts and

personnel reductions in the Medical Department would cripple a model health care delivery system, lower morale, and limit the department's ability to attract new members. Most recently, he urged the three military medical departments to work together to resist further erosion of military medicine. His proposal: a joint chiefs of medical services to plan, program, and allocate military medical resources.

All volunteer force. Admiral Custis became Surgeon General only months before the doctor draft was abolished, a move that forever altered the way the Medical Department did business. Newly adjusting to a peacetime environment, the Navy lost much of its medical strength, primarily general medical officers and flight surgeons. The incentives needed to attract good physicians—pay competitive with the civilian market, modern facilities, high-quality education and training programs—were mostly promises; little legislation had been passed to guarantee their availability.

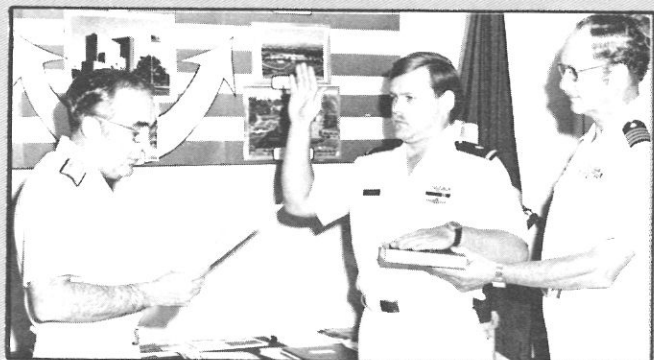
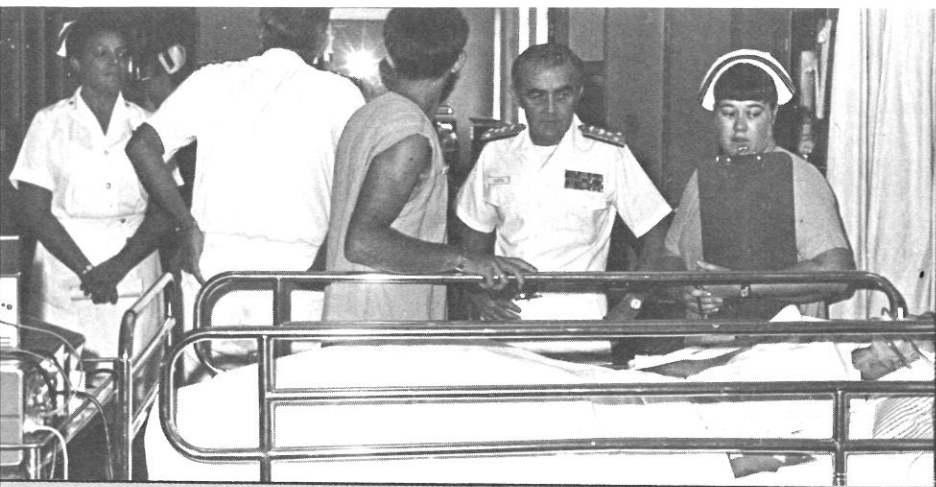
Navy medicine was also feeling the effects of inflation: operating costs soared while budgets were reduced. It was soon common knowledge that the Navy was in the thick of a health care crisis, and that bold programs and resolute leadership were needed.

Admiral Custis proved to be the right man for the job, guiding the Medical Department into creative pilot programs from which emerged a flexible new health care delivery system. To support the operating forces—Navy medicine's primary mission—he approved programs of fleet medical pools, aviation medical officers, and remote medical

diagnosis systems, as well as a new residency in operational medicine. To compensate for reduced numbers of primary care physicians, he tagged other members of the Navy health care team for expanded roles and responsibilities: Medical Service Corps officers took command at six Navy hospitals; Navy nurses were trained as Ob/Gyn, pediatric, and family nurse practitioners; physician's assistants were introduced at many facilities; and better use was made of Reserve Medical Department personnel, newly transferred into restructured medical units.

An accelerated five-year program of medical facility construction and modernization also received Admiral Custis' support. New Navy hospitals went up at Roosevelt Roads, Camp Pendleton, Charleston, New London, Corpus Christi, Pensacola, and New Orleans, the latter scheduled to open late this year. Twenty-three smaller facilities are under construction, and work begins soon on replacement facilities for NRMCMC Bremerton and the National Naval Medical Center. The first steps have been taken to transfer U.S. Army Hospital Okinawa to the Navy. Also going up is the Navy's newest and largest dental treatment and training facility, to open in San Diego next year. In most of these new facilities, clinical and administrative services will be supported by the latest automated equipment.

Admiral Custis called upon Medical Department personnel to develop and use their talents to the fullest. In particular, he encouraged women to participate and compete. During his administration the Navy placed more women on active duty as physicians than ever before in its



VADM Custis led the Navy Medical Department for nearly 3½ years. Shown here are some of the stops along the way: (clockwise from top left) VADM Custis observes patient care at U.S. Naval Hospital Guam; speaks to the staff of Naval Hospital Boston, Chelsea, Mass.; tours the National Naval Medical Center with commanding officer RADM D. Earl Brown, Jr. (MC); ponders a hairy problem on a trying day; reviews medical records at Naval Aerospace and Regional Medical Center; visits Naval Reserve Medical Co. 9-4 in Kansas City, Mo.; gives a TV interview at Naval Hospital Orlando, Fla.; and swears in the next generation of Navy medicine.

history; their assignments, and the growing acceptance of women as full partners in all Medical Department corps, reflect the true spirit of equal opportunity.

Active service. Admiral Custis was born in Goshen, Indiana, on 23 July 1917. He received his bachelor of arts degree from Wabash College, Crawfordsville, Indiana, in 1939. Commissioned an ensign in the U.S. Naval Reserve in December 1941, he completed his medical training at Northwestern University and received his M.D. degree in 1943.

After serving his internship at the Presbyterian Hospital in Chicago, Dr. Custis was ordered into active naval service in October 1944. He subsequently received instruction at the Small Craft Training Center in San Pedro, California, before joining the USS *Clinton* (APA-144) as a junior medical officer in February 1945. After serving as medical officer in the Pacific theatre of World War II, he was released from active naval service on 1 August 1946.

Upon returning to civilian life, Dr. Custis completed a surgical residency at the Mason Clinic in Seattle, and established a private surgical practice in that city. He was certified by the American Board of Surgery in 1951. From 1955 to 1956 he was a member of the American Medical Association's Council on Medical Education, evidencing the personal interest in medical education he would later project with considerable impact on the Navy Medical Department.

Dr. Custis accepted an appointment as commander in the Navy Medical Corps on 8 October 1956, and joined the surgical staff of Naval Hospital Portsmouth, Virginia. Subsequent assignments included: chief of surgery, U.S. Naval Hospital, Guantanamo Bay, Cuba; assistant chief of surgical service, Naval Hospital Great Lakes, Illinois; chief of the surgical service, Naval Hospital Beaufort, South Carolina; and chief of surgical service and executive officer of Naval Hospital

Philadelphia, Pennsylvania. He was promoted to the rank of captain on 1 February 1961.

In May 1969 Dr. Custis became senior medical officer at the U.S. Naval Support Activity, DaNang, Republic of Vietnam. At considerable personal risk, he provided the professional leadership that ensured the full measure of operational support upon which military forces depend. He was later awarded the Legion of Merit with Combat "V" for "exceptionally meritorious conduct . . . while serving with friendly foreign forces engaged in armed conflict against

the Viet Cong and North Vietnamese Communist aggressors" He was also awarded the Armed Forces Honor Medal First Class by the Republic of Vietnam.

On 17 July 1970, Dr. Custis assumed command of Naval Hospital Bethesda, with additional responsibility as deputy commanding officer of the National Naval Medical Center. He was promoted to the rank of rear admiral on 1 September 1972, and advanced to vice admiral six months later upon his appointment as Chief of the Bureau of Medicine and Surgery and Surgeon General of the Navy.

New Deputy Chief

RADM Paul Kaufman (MC), assistant chief for planning and logistics of the Bureau of Medicine and Surgery since 1974, took over as deputy chief of BUMED and assistant chief for headquarters operations on 1 July 1976. He succeeds RADM Charles L. Waite (MC), who has retired (*see box*).

In his new position, RADM Kaufman will act for the Surgeon General in his absence and serve as chairman of the Medical Department's Budget Advisory Council and Policy Board.

It's a far cry from RADM Kaufman's first job: in his early teens, BUMED's new deputy chief drove a dump truck and bulldozer and worked as a grease monkey on a power shovel.

Born in Bay Shore, New York on 24 March 1923, RADM Kaufman won a scholarship to New York University, earning his B.A. degree in 1943. He received his M.D. degree in 1947 from George Washington University, Washington, D.C., where he was in the top 10% of his class. After interning at the District of Columbia General Hospital, he completed a pediatric residency at the Washington, D.C. Children's Hospital.

Commissioned in the Navy in September 1950, RADM Kaufman served at the Naval Gun Factory, Washington, D.C.; Naval Hospital Bethesda, Maryland; and in the *USNS General W.T. Gordon* until he was released from active duty in 1952 and entered private pediatric practice in Arlington, Virginia. He returned to active duty in July 1959 as chief of pediatrics at Naval Dispensary, Washington, D.C. After attending the Naval War College, Dr. Kaufman served as deputy



RADM Kaufman
Deputy Chief of Bureau

surgeon for the Commander in Chief, U.S. Pacific Fleet and Commander in Chief, Pacific (1962-65). In 1965 he became deputy director of the BUMED Planning Division (and was named director in 1968), with additional duty as medical adviser in logistics to the Chief of Naval Operations. RADM Kaufman subsequently was named director of clinical services and executive officer of the National Naval Medical

Center, with additional duty as personal physician to the chairman of the Joint Chiefs of Staff. He became the first commanding officer of Naval Regional Medical Center, Jacksonville, Florida, when that facility was established in 1972.

RADM Kaufman holds the Meritorious Service Medal, Joint Service Commendation with oak leaf cluster, Navy Commendation Medal, Naval Reserve Medal, Combat

Action Ribbon, American Campaign Medal, World War II Victory Medal, National Defense Service Medal with star, Korean Service Medal, Vietnam Service Medal with star, and the United Nations Service Medal.

A Diplomate of the American Board of Pediatrics and National Board of Medical Examiners, he is a member of many professional organizations.

RADM Waite Retires

RADM Charles L. Waite (MC), deputy surgeon general of the Bureau of Medicine and Surgery since July 1975, retired from naval service on 1 July 1976, ending an impressive and varied career in Navy medicine.

In his years at BUMED (1973-76), RADM Waite became the first assistant chief for operational medical support when all operational medical specialties were consolidated under BUMED Code 5. Later, as deputy surgeon general, he initiated and guided a management by objectives program, establishing milestones for the Medical Department's future. He was also chairman of the planning board which reorganized BUMED and developed the Naval Health Sciences Education and Training Command and the Naval Medical Research and Development Command.

Born in Washington, D.C. on 18 March 1923, RADM Waite received his B.S. degree from Georgetown University in 1943, the same year he was commissioned an ensign in the Naval Reserve. He received his M.D. degree from Georgetown University under the V-12 Program, and was commissioned a lieutenant (junior grade) in the Medical Corps of the Naval Reserve in 1946. After interning at Naval Hospital Bethesda, Maryland, he attended naval diving school and line officer sub-

marine training, then served as medical officer of Submarine Squadron Three. In April 1949 he joined the staff of Children's Hospital, Washington, D.C. as a resident physician.

RADM Waite served as medical officer of the Naval School for Deep Sea Divers, Washington, D.C. from 1950 to 1951, serving additional duty with the expert diving unit and underwater demolition team. After transferring from the Reserve to the regular Navy in 1951, he returned to Naval Hospital Bethesda as senior resident in pediatrics. He joined Submarine Squadron One in 1952 as medical officer, with additional duty as acting force medical officer, Submarine Force, U.S. Pacific Fleet; senior medical officer of Naval Dispensary, Submarine Base, Pearl Harbor; and submarine escape training tank officer.

RADM Waite then returned to the practice of pediatrics at Naval Hospitals Bethesda, Jacksonville, and Philadelphia. In 1962 he joined the staff of Commander Submarine Forces, U.S. Pacific Fleet, and in 1964 took command of Naval Submarine Medical Center, Groton, Connecticut. Other assignments included executive officer of Naval Hospital Portsmouth, Virginia, and commanding officer of the Naval Medical School, National Naval Medical Center. Selected for flag

rank in 1971, RADM Waite became medical officer of the U.S. Pacific Fleet and joint command surgeon for Commander in Chief, Pacific. In 1973 he reported to BUMED, where he was named deputy surgeon general in 1975.

RADM Waite holds the Meritorious Service Medal, Joint Service Commendation Medal, Navy Commendation Medal, World War II Victory Medal, American Campaign Medal, Navy Occupation Service Medal, Korean Service Medal, Korean Presidential Unit Citation, Vietnam Meritorious Unit Commendation (First Class with Palm), Vietnam Service Medal, China Service Medal, United Nations Service Medal, and National Defense Service Medal with bronze star.



RADM Waite
Ends Navy career

Humans: Handle With Care

Whether it begins with rats, dogs or fruit flies, medical research eventually lands on the human doorstep. To safeguard human subjects in Navy medical experiments, BUMED recently moved to police such projects more closely.

Under BUMED Instruction 3900.6 of 2 April 1976, BUMED activities doing research on humans must establish a Committee for the Protection of Human Subjects composed of at least five members selected for their maturity, experience and expertise. The Committee must include a lawyer and clergyman whenever possible. Its job: to decide whether the potential risk to subjects outweighs possible benefits from a proposed study.

The protection committees at BUMED activities will judge proposed human research studies according to applicable laws and regulations, standards of professional conduct, and ethical and community standards. Committee members will look for:

- adequate protection of the subject's rights and welfare.
- possible benefits that justify exposing the subject to risk.
- the subject's legally effective consent.

To be "legally effective," the subject's consent must be voluntary and informed: a scientifically competent person must discuss the project with the prospective subject in front of a witness not involved in the study. This discussion must cover:

- procedures to be followed, their purpose, and information about which procedures are experimental.
- possible discomforts and risks.
- potential benefits.
- alternative procedures the subject might prefer.
- provisions of the Privacy Act of 1974.

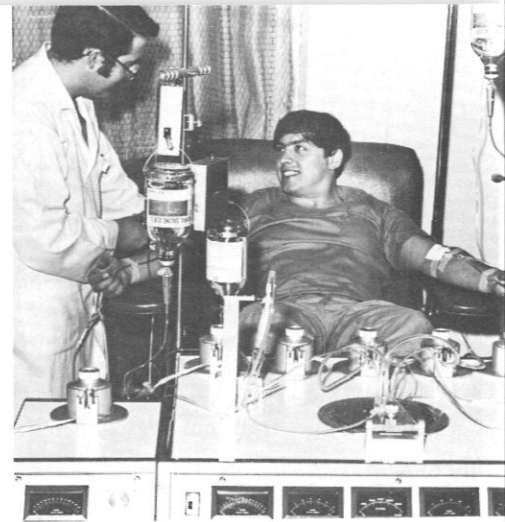
The researcher must offer to answer the subject's questions, and must tell the subject he is free to withdraw from the experiment at any time without penalty.

The subject's consent must be in writing whenever possible, although oral consent is acceptable under exceptional circumstances. Implied consent is prohibited, and the subject may not be required to waive his legal rights. Third party consent is acceptable only when the prospective subject cannot understand the project well enough to give informed consent—a child, for instance.

Acceptable risk. Studies involving human subjects must contribute significantly to an approved Navy research program and have a reasonable chance of yielding important results not obtainable through other methods. The number of human subjects must be kept to a minimum. Only scientifically qualified researchers may conduct the study, and they must be ready to release the subject whenever further experimentation is likely to cause injury, disability or death. To assure acceptable risk, researchers must complete sufficient animal and laboratory experiments before using human subjects.

Subjects must have no mental or physical condition which would make their participation more hazardous than for a normal healthy person, unless the condition itself is the subject of study. Prisoners, prisoners of war and institutionalized mental patients are not to be used as subjects.

As an additional safeguard, a physician or dentist not connected with the research will conduct periodic health checks on all subjects. Subjects will be given any medical or dental treatment they require as a result of their participa-



Naval Medical Research Institute study

tion, and will be hospitalized promptly in case of emergency.

The Committee for the Protection of Human Subjects will review approved studies once a year, more frequently if significant risk is involved. Complications—accidents, unexpected drug reactions, diseases or injuries—must be reported to BUMED Code 0012 within 48 hours.

Human volunteers are participating in Navy experiments on the effects of sleep deprivation, motion, diving, flying, heat stress, and in tests of new medical procedures and drugs. Most volunteers are recruited locally by research activities, and most have some experience in the field being studied. Navy divers, for example, volunteer as subjects of diving research.

Patients in Navy hospitals are sometimes asked to volunteer as subjects for new medical procedures and drugs. A recent example: At the National Naval Medical Center, a 10-year-old patient with aplastic anemia received two bone marrow transplants from his 16-year-old sister. The youngster is doing well at home, after what is still considered an experimental procedure.

The new precautions should ensure that such subjects are adequately protected, and that the benefits and knowledge to be gained justify their accepting any involved risk.

BUMED SITREP

CONTRACTS AWARDED . . . Construction contracts have been awarded for two new naval medical facilities. Santa Fe Engineers, Lancaster, California will build the 170-bed replacement hospital at Jackson Park, Bremerton, Washington. The current working estimate for this project is \$26,639,000. Blake Construction Co. of Washington, D.C. will build the new inpatient and outpatient addition to the National Naval Medical Center, Bethesda, Maryland. The current working estimate is \$95,000,100, which includes some utilities and roadwork.

MEAL PASSES . . . Meal passes have attracted the attention of the Naval Audit Service. Commanding officers are reminded that:

- Meal pass logs should indicate valid outstanding passes, and should be annotated when personnel are transferred or authorized commuted rations.
- Unissued meal passes must be numbered and retained under secured conditions.
- Meal pass logs should be compared against disbursing records to determine personnel on commuted rations.
- Personnel leaving the command must surrender meal passes.

FY76 DEDUCTIBLE . . . CHAMPUS eligible beneficiaries, accustomed to paying up to \$100 per family as a deductible each fiscal year, are getting a break: for the purpose of computing CHAMPUS deductibles, FY76 has been extended three months to include the period 1 July-30 September 1976. After that, deductibles will apply to fiscal years running from 1 October to 30 September.

SUITABILITY FOR ASSIGNMENT . . . Some active-duty personnel and their dependents still arrive at oversea and remote duty stations with serious clinical conditions beyond the treatment capabilities of nearby medical activities. Responsibility for determining suitability for assignment rests with the member's CO, who relies on the medical officer's recommendations in health matters. In screening members and dependents for such assignments, medical officers must adhere strictly to the requirements set forth in BUPERSINST 1300.26E, BUPERSMAN 1830200,

MANMED Art. 15-50, and SECNAV-INST 6320.8D. Continuing liaison with personnel officers can ensure timely notice of a member's scheduled transfer, allowing time to complete personnel evaluations and medical records review.

CAPOC . . . NRMCS San Diego, California and Portsmouth, Virginia have been selected as the initial Navy sites for installation of tri-service Computer Assisted Practice of Cardiology (CAPOC) systems. The Navy will also have access to CAPOC systems installed at five other military medical facilities within the U.S. Anticipated installation dates are August 1977 for San Diego, and December 1977 for Portsmouth.

CAPOC uses computer-compatible three-channel recording equipment to transmit electrocardiogram data between a medical treatment facility and a central computer site. Standard direct dial telephone service is used to submit ECG data and return analysis reports. CAPOC will:

- Increase the quality of patient care, and provide emergency cardiology service to outlying medical facilities.
- Reduce the time needed to read, interpret and transmit the results of ECGs to the submitting medical facility.
- Increase the productivity of cardiologists and technicians.
- Establish a standardized ECG processing system within DOD.

SAN DIEGO . . . The Navy is now requesting 800 acute care and 300 light care beds for its new medical center to be built in San Diego's Murphy Canyon. Size was determined by the population to be served and the Navy's need to support its medical training mission. Single year funding of the medical center is being requested for FY79.

PERFORMANCE EVALUATIONS . . . The importance of performance evaluations for hospital corpsmen has been dramatically illustrated since the HM rating was placed in Career Reenlistment Objectives Category E (CREO-E) on 1 January. Corpsmen's requests for reenlistment or extension on active duty are now screened by BUPERS, with only the fittest of the fit selected. Bland and mild command endorsements can eliminate from consideration personnel who might be excellent career hospital

corpsmen. Glowing endorsements of individuals with poor or mediocre records may permit their selection over better qualified people.

From 1 January to 17 February 1976, some 470 HM personnel came under CREO-E criteria. Of these, 226 required action by the Chief of Naval Personnel. Fifty-two members asked for extension of active duty: only 21 were approved. Of 175 members requesting reenlistment, 64 were disapproved and 18 converted to other ratings. These statistics may be a sign of what to expect for the rest of the year.

URINALYSIS TESTING RESUMED . . . Navy and Marine Corps random urinalysis testing, temporarily suspended on 5 March, has been resumed. All five Navy urinalysis laboratories will remain open while DOD completes a tri-service study of resource requirements.

DEPENDENTS' OUTPATIENT RECORDS . . . Dependents' outpatient records may be transferred to a new activity in the custody of the sponsor, spouse, or other adult dependent. Records may also be transferred by mail at the request of the sponsor, spouse, or the medical facility where the patient will be seen. Generally, it is best for the records to be hand-carried; this method best assures continuity of care and elimination of duplicate records. Medical activities should publicize the transfer options provided by BUMED Instruction 6150.1D, emphasizing the advantages of hand-carrying records.

DATA PROCESSING . . . BUMED is participating in the DOD Automated Data Processing Equipment Reutilization Program, through which excess Government-owned equipment is reused with substantial savings in rental and lease costs. BUMED now owns 35 of its 36 computer systems. Only the system at the Naval Medical Research Unit No. 2, Taipei, is rented. There are also 199 punched-card accounting machines and other support automated data processing equipment, such as cathode-ray tube terminals not directly on line to an in-house computer, installed at BUMED activities. Forty-four of these machines are Government owned.

Reserves

Why Stay Reserve?

CAPT Matt H. Backer, MC, USNR-R

Most physicians enter the Medical Corps via the Naval Reserve. In fact, over the last 30 years most doctors on active duty have been Reservists. For as many years, several hundred physicians have left active duty each summer to return to civilian practice, to industrial or academic careers, or to pursue further training. Some years as many as 1,000 physicians leave the Navy. Most of these doctors have spent just two or three years on active duty and have some remaining Reserve obligation; they usually remain inactive, but are carried on the Reserve roster three or four more years and are then discharged. A second, smaller group leaves each year, most of whom received specialty training in the Navy and who have had five to eight years of active duty.

I am surprised that more of these physicians do not remain active in the Reserve, particularly if they have already served on active duty for some time. The years of Reserve participation required to qualify for retirement are so few, and they go by so quickly, that it seems wasteful and unwise not to complete them.

Just after World War II, and even after the Korean conflict, medical officers had considerable interest in Reserve participation, even though there was no structured medical program and drill pay billets were

limited to doctors who performed physical examinations at Reserve centers. So many and so enthusiastic were these World War II veterans that volunteer Reserve medical divisions were formed in several large cities; in 1949 these divisions coalesced in several areas to form Naval Reserve medical companies.

Until 1949, a physician received longevity credit toward Reserve retirement if he merely remained on the roster; little active effort was required on his part. Many doctors who had three or four years of active duty in World War II and another three or four years in the Reserve were well on their way toward a 20-year Reserve retirement; they had good reason to stay in. (Since 1949, however, it has not been enough just to belong to the Reserve. A physician must participate to make his Reserve years count toward retirement.)

During the Korean War, some medical officers who were recalled to active duty had received their training under the V-12 Program and had completed school too late to serve during World War II. Not all were happy about the call-up, but many continued to participate in Reserve medical companies, often without pay. Some of the largest and strongest medical companies were in the Midwest—at Kansas City, and Rochester, Minnesota (Mayo Clinic), for example.

Why don't young doctors remain active in the Reserve today? Undoubtedly, we've been so busy securing physicians for active duty that we haven't done enough to tell people about the advantages of a

Reserve career. Until recently, hospital commanders have had little reason to know much about Reserve programs and so have not been able to advise physicians about them. Constant changes in the programs over the last several years have made it difficult for even career Reservists to understand them and explain them to others. The constant reorganization of Reserve programs hurt recruitment and retention.

There are other reasons: Unhappy active-duty experiences also make it impossible to interest a physician in the Reserves. Conversely, a satisfying active-duty experience frequently causes him to seek out a Reserve unit, often with no outside encouragement.

Finally, the possibility of being recalled to active duty at an inconvenient time discourages many young doctors who might otherwise participate in the Reserves. Historically, no Naval Reserve doctors have been called up since the Korean war, but they undoubtedly will be called in future conflicts. The unpopularity of the Vietnam war and the fact that many physicians were drafted into service have played their part in low Reserve retention.

Despite these problems, there are still many rewards for physicians who participate in the Naval Reserve. And many of the problems previously troubling the Reserves have been solved or are at least under study.

Each medical officer leaving active duty now receives a personal letter from the Navy Surgeon General pointing out the benefits of a Reserve career, inviting him to participate, and telling him where to get more information. The Surgeon General has also enlarged the Bureau of Medicine and Surgery's Reserve Division, relieving the staff of many recruiting duties, and charging it to develop a highly trained and motivated Reserve force to augment the active Medical Corps. In SITREP #15, the Surgeon General and the director of the Re-

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serve Division discussed the structure and importance of the new medical Reserve, charging hospital commanding officers to develop and use this resource wisely.

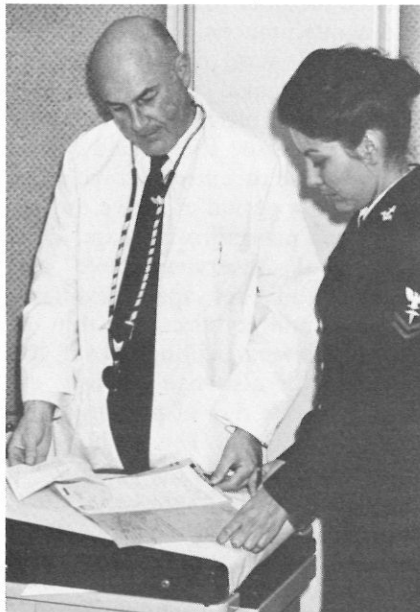
Reserve liaison officers have been appointed in 14 naval hospitals. Articles describing the mission and structure of the new medical Reserve have appeared in *U.S. Navy Medicine*. Also, the experience of medical officers has improved so much that many are remaining on active duty; among doctors who leave, these satisfying experiences may entice them to continue as Reservists.

Reorganization within the medical Reserve is nearly completed, with medical assets better organized than ever before in its history. A highly trained, mission-ready force is emerging. But a large problem remains: funding the new programs. The Medical Corps shares this problem with many other Reserve programs, and it can't be solved at BUMED level. Indeed, the solution may lie beyond the Navy Department, or even the Department of Defense, in the mandate of the Congress to maintain a viable Reserve force. On this score, most career Naval Reservists are cautiously optimistic. We believe that adequate Reserve forces are vital to national survival, though as taxpayers we share the conviction that they must be cost-effective.

To contribute to the defense of one's country is a strong motivation for pursuing a Reserve career. But there are other attractions—good pay and retirement, promotion opportunities, travel, professional development, and privileges accorded military personnel. Here's what you as a Reserve physician can expect:

YOUR PAY STATUS

In the new medical programs, to be described below, most doctors are in a pay status, a change from the many years when most Reserve doctors were not paid. The new programs usually require four drills on one weekend a month. Most doctors



CAPT H.G. Kellogg, MC, USNR consults with his assistant during a Ready Reserve weekend at NRM C San Diego.

in these units are only being paid for two drills per month, but they're also paid for 12 days of active duty each year. While drill pay is still only a sometime thing, more Reserve doctors are receiving more pay today than ever before.

There is considerable debate about whether physicians and many other Reservists who perform duties related to their civilian occupation should receive drill pay. We in the Reserve believe they should. It is unrealistic to expect a young physician to give up a weekend a month for Reserve participation without pay. The physician is paid not only for his medical expertise, but also for his availability for recall and his training and support contributions.

My own pay from the Selected Reserve Program (Reservists in drill pay billets) for 1974 was a little less than \$400 per month, a comfortable supplement to a regular salary.

Opportunities for promotion have never been better. Many senior medical officers have recently retired, and fewer physicians are actively participating in the Reserves—leaving the road free for younger Reservists to move up. In the late

1950's and early 1960's the "lieutenant commander hump" made promotions hard to come by. Each year hundreds of well-qualified lieutenant commanders competed for the 30 to 40 commander promotions available; many excellent Reserve medical officers were disappointed. Today this is no longer true. Moreover, medical officers with five to six years of active duty may have already reached the rank of commander.

Promotion to captain is still tough, but most Reserve doctors who actively participate do make it. And the increase in retired pay in the higher ranks is considerable.

YOUR RETIREMENT

To qualify for Reserve retired pay, you must complete 20 years of satisfactory federal service. This includes time spent on active duty in the Armed Forces plus all Reserve years in which you earn a minimum of 50 retirement points, credited at the rate of one point per drill and one point for each day of active duty. In addition to earned points, 15 gratuitous points are awarded each year for satisfactory performance.

Retired pay begins when the Reservist is 60 years old. Between the time he completes his satisfactory years and the time he reaches 60, the Reservist may transfer into the retired Reserve and do nothing, or he may continue to participate to earn additional pay, and additional points to increase his retired pay.

The formula to compute retired pay is:

$$\frac{P}{360} \times B = \$/\text{month}$$

where P indicates the total number of retirement points acquired, and B indicates the applicable base pay (at age 60) of the grade in which retired. Examples of monthly retired pay at age 60 are seen in Table I. Also at age 60, retired Reservists are eligible for medical care for themselves and their dependents in military hospitals on a space avail-

TABLE I. MONTHLY RETIREMENT PAY AS A TYPICAL RETIRING RESERVIST

Grade	With 5 years' active duty and 15 years' Reserve duty	With 5 years' active duty and 25 years' Reserve duty
0-6	453.02	653.20
0-5	409.77	533.02
0-4	354.69	445.47

able basis, or under CHAMPUS from civilian medical sources. Privileges also include the use of commissaries, exchanges, clothing and small stores, theaters, recreational facilities, and space available transportation via the Military Airlift Command. Reserve retired pay can also be vested in survivors under a survivor benefit plan comparable to that offered active-duty retirees.

If the benefits of active-duty retirement seem far off to young physicians, Reserve retirement must seem all the more so. But I know many Reserve doctors who draw \$500 and more in retired pay each month. I also knew a retired Reserve dental officer who developed cancer at age 62 and slowly succumbed over the next two years. The medical benefits he received through his Reserve retirement prevented his wife from ending up a pauper.

OTHER BENEFITS

The opportunity for travel is one of the most enjoyable features of Reserve participation. While Reserve policy requires a Reservist to report to the nearest facility offering the training he needs, this training is sometimes available only in one place. Reserve physicians also frequently are assigned to billets where their services are needed, even when travel is involved. Over the past 20 years, I have traveled to some 16 naval hospitals in the United States to perform medical duties, and to many other places for duty in connection with seminars, recruiting, and administrative meetings. Even when traveling on my own, being a Reserve officer has

opened the door to new experiences and acquaintances. I have met the Surgeon General of the Argentine Navy, the naval attache in Rio, commanding officers at Roosevelt Roads, Puerto Rico, and Rota, Spain. Most recently, I traveled to Japan for a period of active duty.

For the past several years, drilling Naval Reservists have also been eligible for space available travel on military aircraft within the United States. Drilling Naval Reservists can also use military exchanges—one day of privileges for each day of drill. The exchange is especially useful for the purchase of good quality clothing, tools, toys, and garden supplies. Servicemen's Group Life Insurance coverage up to \$20,000 is also available to members of the Ready Reserve at a monthly premium of \$3.40. This coverage can be continued after transfer to the retired Reserve at somewhat increased, but still modest, premiums up to age 61. Reservists on extended active duty and temporary active duty receive all the benefits of regular active-duty personnel; those on training duty receive most of these benefits, excluding health care for their dependents.

Participation in the Reserve offers many opportunities for professional enrichment. I have yet to serve in a naval hospital without learning about some new method, device, or trick of the trade. Reservists can also contribute. In fact, any Reserve physician anticipating active duty should let people at his target facility know well in advance that he is coming. His services then can be used properly.

Many Naval Reservists enjoy business advantages from their association. Insurance men sell their fellow officers insurance, lawyers obtain clients. I, for example, have delivered babies and done gynecologic surgery for the families of many Reserve associates. Other Reserve activities have a social component, both of their own and through meetings of the Naval Reserve Association, the Reserve Offi-

cers Association, the Navy League or other groups. Just as in the regular Navy, friendships are made which last a lifetime.

HOW TO PARTICIPATE

Under the restructured Reserve program, a Reservist affiliates with a unit and attends that unit's training drills. A variety of programs is available, from submarine forces to Navy air, and from intelligence to Marine Corps support. Only one program, cargo handling, has no opportunities for medical participation. After 1 October 1976, the largest number of medical officer billets will be found in the medical program and the Marine Corps forces program. Physicians affiliated with these areas will organize and train 20 surgical and surgical support teams, hospital detachments for two new amphibious assault ships, two advanced base hospitals of 50 beds and 100 beds, and the full spectrum of support for four Marine divisions and four air wings.

Regular monthly drills are generally divided between professional training and medical support to other drilling Reserve communities. Long-term training plans cover a three-year cycle with annual duty for training varied between professional tours by units or subunit teams at naval regional medical centers, duty at sea or in landing force exercises with the Marines, and solo tours. In the last category are military medical schools (including a special course for Reserves in aviation medicine at Pensacola), national security seminars, training for command and staff assignments, and even the rare two-week tour overseas to Europe or the Far East.

Pay for participation (24, 36, or 48 drills a year) varies according to the priority of the program. "Combat" and "combat support" programs usually qualify for more paid drills than do programs designated "base support." It is expected that priorities will be reordered and new

guidelines set for drill pay after 1 October.

As in the active force, a Reservist may be given additional duty in other formal programs besides his regular drilling affiliation. The two most important such assignments are as a lecturer/consultant and medical school liaison officer. As a lecturer/consultant, the Reservist performs part of his drills in support of graduate training programs and specialty health care in naval hospitals. As a liaison officer (all of whom must hold a faculty or administrative appointment at a medical school), drills are carried out in support of student recruiting for the Armed Forces Scholarship Program, providing a point of contact for Navy scholarship students, and

interviewing and evaluating applicants for appointment to the Medical Corps.

Reservists are also frequently called upon to serve as members of inactive Reserve selection boards, as temporary replacements for active-duty medical officers, and as consultants to the Surgeon General in a variety of areas, such as Naval Reserve policy and planning, cold weather medicine, field medicine, and the clinical specialties.

Reserve officers may apply for temporary or extended active duty. Their assignment depends upon their qualifications and the needs of the active corps. It is also much easier for a Reservist to return to active duty than for a physician without Reserve experience to be

commissioned. This may be another good reason to remain active in the Reserve program: if the grass doesn't prove quite as green on the outside as it looked, there's a good chance you can come back.

I have been convinced for a long time that just being a naval officer means a lot to most Reservists, sometimes more than it means to some of their regular counterparts. The Reserve fulfills our need to get away once in a while, to do something different, to contribute to our nation. The Reserve challenges our leadership, ingenuity, and patience, and sharpens our competitive spirit. Under the "One Navy" concept, participation in the Naval Reserve is well worth the consideration of any adventurous and capable physician.

Scholars' Scuttlebutt

Dear Ensign:

I am happy to respond to your inquiry about a career in aviation medicine.

You're right, aviation medicine is not for everybody. Aviation medicine is general medicine combined with occupational medicine. It is practiced in shoreside clinics in the continental United States, in overseas shore dispensaries and hospitals, aboard ships at sea, in the tents of operational Marine air units—in other words, wherever you find Navy and Marine Corps fliers. Because they must respond to the Navy's operational needs, flight surgeons usually don't have the most pleasant or luxurious surroundings in which to practice medicine; aviation medicine is practiced not in a hospital, but in the field, where the military action is.

You asked whether a flight surgeon has the chance to practice family medicine. The answer is normally no, but it depends on the billet. If you are with a deployed squadron aboard ship, you don't practice pediatrics, geriatrics, or obstetrics and gynecology. But if you are assigned to an overseas shore facility—the naval dispensary in Sigonella, Sicily, for example—you practice the gamut of medicine, *plus* aviation and occupational medicine. In some overseas billets with Marine units you would

have no contact with dependents; in others, you would. No generalization really fits. No two billets are exactly alike, and no rules allot any percentage of your time or talent to a specific area.

You *would* have the opportunity to participate in choosing your billet. Flight surgeons are almost never sent to a billet they don't want. Academic standing is considered when selecting someone for an aviation medicine billet, but with guidance from the faculty, you would also be able to do some horse-trading with your fellow student flight surgeons.

As a flight surgeon, your opportunities for continuing medical education depend on your command's operational commitments. If your squadron is deployed in fleet exercises during the annual meeting of your favorite medical society, you're going to miss the meeting. And of course, Navy-supported continuing medical education is subject to funding constraints. If the Medical Department budget allows, you will be funded for one meeting each year; for flight surgeons, this is usually the Aerospace Medicine Association's annual meeting.

I've observed five qualities in people who enter aviation medicine:

- desire to fly.
- desire to practice aviation medicine.

- an adventurous spirit.
- acceptance of military society's structure.
- willingness to postpone a permanent commitment to a clinical specialty.

If you've got two of these five qualities, aviation medicine is probably a good career choice; if you've got three of the five, you and aviation medicine are probably perfect for each other.

But if you're committed to traditional hospital-oriented family medicine as practiced from an office or at bedside, aviation medicine is probably not for you. We in aviation medicine are into more than these traditional clinical contacts: we're involved in preventive medicine, aircraft accident investigation, teaching, and practical, applied psychology and psychiatry. If I may use your words, there are no "joy rides" or places for marking time. The operational flight surgeon often must work without the security of a full hospital staff ready for consultation. It's a challenge—but if you can meet the demands, you'll be involved in a brand of medicine you won't find anywhere else.

If you think you're interested in joining us, write us at the Bureau of Medicine and Surgery, Code 51, 2300 E St., N.W., Washington, D.C. 20372.

Sincerely,
A Navy Flight Surgeon

Social Psychology for Medical Officers

CAPT Martin R. Plaut, MC, USN

The United States spends eight percent of its gross national product on health care. We have more doctors, more medical facilities, more sophisticated medical technology and higher health care standards than most other nations. Yet the continual demand for better health care implies that our present system is not good enough, that nothing less than a fountain of youth would do—preferably admission-free (1, 5). While the demand is for more affordable and accessible health care, the free enterprise, competitive price system has made medical care very expensive, and the cost is still rising.

The medical profession, an easy target, is blamed for the high cost, not just of the physician's fee but of hospitalization, drugs, and diagnostic and therapeutic equipment as well. Critics say, for example, that because there is no free market for medicine, the medical profession controls its own product. Insurance plans, they say, are designed to protect the doctor, not the patient. The fee-for-service system permits the doctor to conduct his practice like any other business venture—he sells his services to the highest bidder, and is not above the sharp practices found elsewhere.

The medical profession has generally conceded that the U.S. competitive price system has forced it to adopt such business practices, even when they are inconsistent with traditional medical altruism, and it sees nothing wrong with such

behavior. It also believes that only the profession is qualified to judge what kind of medical care is good for the country, and that no one should be allowed to dispense such care without its cooperation at the very least. The medical profession wants to remain the guardian of health in the U.S., and to limit government control over its activities. At the same time it agrees to yield, within reason, to the pressure of social evolution. This formidable task it hopes to manage as an adviser rather than a functionary in defining government support of medical education, research, and health care delivery. The intent is to avoid total government sponsorship of medicine in the U.S. (7).

But when the economic system leads to health care costs that most consumers cannot afford, who but the government is left to foot the bill? The U.S. is heading toward socialized medicine, and it may be only a matter of time until we have a national health insurance plan (1, 2, 3, 4, 5).

To many people, government-administered medicine is just one more sign of bureaucracy's overinvolvement in their private affairs. They doubt that government can provide care as good as that provided by the private medical sector, and they don't believe that national health insurance would give them access to inexpensive private health care.

The discontent with our current system of health care goes beyond economics. It also mirrors our psychology. We no longer accept illness as inevitable. Health is no longer a cherished blessing but a

constitutional right. With our many privileges and few obligations, we are not content merely to count our blessings: we have the means to seek even greater security, particularly protection against medical catastrophe. We tend to emphasize souped-up emergency and intensive care services over prevention, rehabilitation, and care for the disabled, chronically ill, aged and mentally unbalanced. We show concern over heart disease, cancer, and stroke, which we find particularly threatening to ourselves and our families. We eat, drink and smoke too much, take drugs, drive recklessly. Meanwhile we delude ourselves by imagining that everything would be better if we only had equitable health care.

How do these problems affect the Navy medical officer? As a member of the medical profession, he must (at least tacitly) support the medical "industry" and share with his civilian counterparts the blame for medical care inadequacies. And, as a highly visible government representative, he must be accountable for the quality of his work. But his status as a military officer compounds the problems he faces as a physician. While he may be popular during times of war, in peacetime he is considered expendable and anachronistic, and his specialty of military medicine is threatened with extinction, along with the armed forces it serves (6).

As a practitioner of pure socialized medicine, the military medical officer is the target of skepticism. His services may be taken for granted or used indiscriminately. His patients feel entitled to tell him

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what to do because they have paid for his services through their taxes. Because he has chosen to be non-competitive in the economic world, his patients suspect he lacks the drive and competence one finds in private practice. They overlook the fact that he competed to achieve his professional goals and military rank, and they are often unaware of his personal achievements and the opportunities for professional excellence and human development in the military. They see the military physician as a mere tool of the bureaucracy, as part of a system that can be mediocre because it need not cater to the consumer. They believe all this despite the fact that the military medical officer works in the name of service, not for profit; most people find it hard to believe physicians are motivated by anything other than economic self-interest.

A measure of behavioral psychology and applied sociology is a necessary tool in today's world of military medicine. Despite the complaints we hear about medicine in general and military medicine in particular, we have a high-quality product that is readily accessible and humanely and equitably delivered. And if the Navy medical officer balances his liabilities against his assets, he will find that he is still needed and that he can practice medicine in a manner satisfactory to himself and his patients.

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Enlisted Scene

New advancement, frocking policies

The Chief of Naval Operations recently announced revised advancement and frocking policies for enlisted personnel.

The new advancement system should eliminate much frustration and uncertainty among selectees for advancement who, until now, did not have a firm advancement date until well into their advancement cycle.

Under the new system, each advancement cycle is divided into two equal segments. At the start of each cycle, selectees are notified of their assigned advancement segment. One month before advancements begin in their segment, selectees will be given a specific advancement date. In rare cases when a firm advancement date cannot be set, the Chief of Naval Personnel (CHNAVPERS) will authorize frocking of affected personnel effective the first day of their segment. Frocking on the earliest possible date will be authorized if CHNAVPERS must delay an assigned advancement date.

These procedures are effective with the February 1976 E-4, E-5 and E-6 examinations. Check BUPERS Note 1430 of 2 March 1976 for details.

Defense manpower changes recommended

Major changes in military compensation and retirement, and retention of the military's "institutionalized benefits" are recommended in the Defense Manpower Commission's April 1976 report to Congress and the President.

A six-member panel, the Defense Manpower Commission was created by Congress in 1973 to study DOD manpower requirements and costs.

The report calls institutional benefits such as free medical care, commissaries and exchanges "essential," and proposes a bill of rights for service members which would specify these benefits and guarantee that they will not be changed while an individual remains in the military service.

Military compensation should be competitive with private industry and sufficient to attract and retain high-

quality personnel, the report says. The Commission also proposes establishing a federal compensation board to review compensation-related issues. Items currently comprising regular military compensation should be converted to a fully taxable military salary, the Commission recommends, and higher compensation for married servicemen should be eliminated.

The Commission advocates maintaining the noncontributory retirement system for career-designated personnel only. Career designation would come after 10 years of service, and retirement after 30 years; earlier retirement would be reserved for personnel who serve in combat jobs. Career members who serve less than 30 years would be eligible for a reduced pension at age 60 or 65 (Congress would decide which). This 30-year retirement program would apply only to men and women who enter military service after the new program is implemented.

The Commission supports strengthening the Navy, particularly antisubmarine warfare forces. Because of the continuing Soviet defense buildup, DOD should maintain a force of 2.1 million military personnel and 1 million civilians through 1986, the report says.

Other recommendations:

- Use education as a recruiting incentive. If existing G.I. Bill benefits are terminated, create a DOD-funded educational assistance program.
- Grant educational benefits selectively to meet critical needs for certain skills.
- Consolidate training programs and recruiting efforts for the three services, where possible.
- Resume the standby draft system, with annual registration and classification of 18-year-olds.
- Abandon the "up or out" promotion system in favor of a carefully selected career force.
- Abolish the standby Reserve, and require all Reservists to remain in the Ready Reserve.

The Commission strongly opposes unionizing the military services.

Congress and the President are studying these suggestions. Some could be implemented through executive action; others require legislation.

—HMCN Horace S. Anderson, Master Chief Petty Officer of the Force, Bureau of Medicine and Surgery, Code 006.

NAVMED Newsmakers

Five fledgling ambulance drivers rushed to aid the stricken corpsman, lying unconscious, blood trickling from his head, hand and leg. But on closer inspection they noticed far more disturbing symptoms: the wounded man was snoring softly, and that mean-looking cut on his forehead was cleverly crafted with fingerprint. **HM1 Richard L. Charett** did his realistic patient act as a final exercise for his advanced first aid class at **NRMC Camp Lejeune**. The graduates, who won a standing ovation from their formerly prone "patient," are Marine **LCPLs Kreig Bartley, Dean Eisenhower, Emily Bartley and Bobby Ferguson**, and **PFC John Mosier**.

Meanwhile, at Marine Corps Air Station El Toro, Calif., another pair of ambulance attendants were in the eye of some real medical excitement. **HM3 Eduardo Weddle** and **HA Nancy Moore** of the station dispensary tried to drive a Marine wife to **NRMC Long Beach** before her baby arrived. When they saw the baby wouldn't wait that long, the two corpsmen carried out the delivery in the ambulance without a hitch. Says **HA Moore**: "We were prepared, thanks to the training we got at Corps school."

What does a Navy doctor do for an encore after he rockets through space with the first U.S. Skylab? **CAPT Joseph Kerwin (MC)**, the Navy's only astronaut-physician, doesn't sit around watching "Star Trek"—he's working on the space shuttle, slated for atmospheric testing in 1977 and orbital testing in mid 1979. Anticipating another space hop, **CAPT Kerwin**, 44, keeps his flight status current by logging the required 100 flying hours a year.

Athletes at Naval Aerospace and Regional Medical Center Pensacola have done it again. And again...and again...and again. Some 60 medical and dental sportsmen there have won the Naval Air Station Pensacola captain's cup for the fourth consecutive year. The cup goes annually to the best Navy intramural athletics team in the Pensacola area. Our champs from the medical center showed their stuff in a wide range of sports, including table tennis, softball, football and golf.



Charett: No problem

SGT Brenda A. Lanclos



SGT Ken Barnes

Weddle and Moore: No hitch

It didn't look like the surgeon general. But no mistake, it was—the surgeon general of Norway, that is. Major General **Alv M. Johnsen**, Director General of Norwegian Medical Services, stopped by the Field Medical Service School at **Camp Pendleton, Calif.**, on a cross-country tour of Navy medical facilities. **CDR Fred Smith (MSC)**, assistant medical supply officer, offered the Norwegian SG a tour of the contents of a battalion aid station medical supply kit.

"I couldn't talk to anybody unless I was loaded," says former Navy hospital corpsman **Bill Boyles** of his trying years as an alcoholic. But **Boyles**, 29, turned



MAJGEN Johnsen: No mistake

his life around through Alcoholics Anonymous. Now he helps others as coordinator of **NRMC San Diego's** alcohol and drug abuse program for civilian employees. **Boyles** advises supervisors to be alert for the early symptoms of alcoholism—increased absenteeism, poor performance at routine jobs, being late for work a lot. "The earlier we find out something is wrong," he says, "the better the chances for overcoming it."

Policy

Instructions and Directives

Procuring medical and dental lectures

Civilian lecturers for Medical Department education, training and research programs must be diplomates of an American specialty board (for medical and dental), or recognized outstanding specialists in their field. Lectures may include formal classes, bedside teaching, ward rounds and demonstration of techniques.

Commands must pay lecturers from local operating resources, obtaining these funds in regular annual budget requests. The standard stipend is \$50. Before the start of each fiscal year, commands shall send BUMED Code 3 or 6, as appropriate, a list of approved lecturers, their addresses and specialties.—BUMED Instruction 4235.3B of 11 February 1976.

Safe shipping of etiologic agents and biomedical materials

Etiologic agents—live microorganisms or their toxins which may cause human disease—must be safely handled and properly packaged and labeled. Indigenous etiologic agents shipped within the U.S., its territories and possessions need an etiologic agent/biomedical material label only; shipments from overseas medical facilities to the U.S., and exotic agents shipped to or within the U.S. must carry an importation or transfer permit label, available from naval environmental and preventive medicine units.

Certain etiologic agents, such as hemorrhagic fever agents and lassa virus, must be shipped by registered mail or an equivalent system. Receipt of these shipments must be acknowledged immediately. If the shipper is not so informed within five days after the expected delivery date, he must notify the nearest naval environmental and preventive medicine unit. The unit will try to locate the package, and notify the Center for Disease Control if it cannot be found in 48 hours.

Shippers of etiologic agents and biomedical materials from overseas stations should adhere to regulations of the host country as well as to naval regulations.—BUMED Instruction 6210.3 of 9 March 1976.

Health hazards of trichloroethylene

Trichloroethylene (TCE), a solvent used in the Navy to degrease metal parts, is a potent liver carcinogen in laboratory mice and may induce cancer in humans. Workers who breathe enough TCE can experience disturbed vision, confusion, nausea and vomiting.

Although rare, kidney and liver injuries have been attributed to TCE overexposure.

Commands using TCE shall alert the Medical Department and substitute a less toxic solvent, such as methylchloroform (1, 1, 1-trichloroethane) or perchloroethane, if possible. Personnel exposed to TCE on the job shall have periodic health examinations. A naval industrial hygienist shall evaluate the adequacy of engineering controls and personal protective gear to ensure that workers are not exposed to an average concentration of TCE in excess of 100 parts per million parts of air over an 8-hour day, or to more than 150 parts TCE per million parts air for any 15-minute period during the day. Commands must educate personnel who work around TCE about the health hazards of the solvent, necessary precautions, and first-aid for TCE overexposure.—BUMED Instruction 6260.22 of 18 March 1976.

Medical Command Inspection Schedule

The Inspector General, Medical has announced tentative dates through June 1977 for BUMED command inspections and professional/technical visits to Navy medical facilities. Command inspections of naval regional medical centers include inspections of all regionalized activities. Commands will be notified of exact dates about two months before the inspection.—BUMED Notice 5040 of 5 April 1976.

Security review and approval of professional articles

Professional articles by military and civilian Medical Department personnel must be cleared by the Chief of Naval Operations, Security Policy, Classification and Review Branch, Office of the Director of Naval Intelligence (OP-009D3) if:

- some aspects are classified.
- any part originated at, or is proposed for release by, the seat of government.
- the article discusses potentially controversial military, national or political policies.
- the article might attract national interest.

Articles based on work conducted under approved Medical Department research, development, test and evaluation projects or the Clinical Investigation Program shall be cleared by the commanding officer of the activity that conducted the work. If the command cannot determine clearance, forward material to BUMED Code 0010 for routing to reviewers.

Military authors should include a disclaimer in each article and send a copy of each published article to the Chief of Information (CHINFO).

When activities hold allotments under Appropriation, Operation and Maintenance, Navy (Medical Care) or Research, Development, Test and Evaluation, Navy (Medicine), local funds may be used without BUMED approval to cover the cost of preparing, publishing and

reprinting professional articles. Other activities must obtain prior approval from BUMED. A copy of the article should be sent to BUMED Code 0010 with a statement of services needed, number of reprints desired, and estimated cost. The National Naval Medical Center will negotiate contracts for purchase of these reprints.—BUMED Instruction 5600.2F of 5 April 1976.

Security review of speeches

Public speeches by military and civilian Medical Department personnel must be cleared by the Chief of Naval Operations, Security Policy, Classification and Review Branch, Office of the Director of Naval Intelligence (OP-009D3) if they:

- cover classified subjects, such as new weapons and atomic energy.
- discuss military, national or political policies.
- contain information that may attract national interest in the Navy Department (such as studies of POW/MIA families, and of naval shipyard workers' exposure to possible carcinogens).
- are major speeches given by a flag officer or equivalent Navy Department civilian.
- might provoke controversy among the military services.

Some speeches do not require security review. These include general and patriotic remarks for a national holiday observance, and speeches presented at a classified or closed symposium.

All speeches resulting from work conducted under approved Medical Department research, development, evaluation and test programs or the Clinical Investigation Program shall be cleared by the commanding officer of the activity that performed the work.—BUMED Instruction 5721.2 of 5 April 1976.

Orthopaedic staffing study

From May through August 1976, BUMED will use the specialty of orthopaedics to test a new way to develop staffing standards for medical mission areas. Each month during the test period, commanding officers shall report the amount and type of work performed in their cast rooms. Data collection worksheets and reporting details are provided in BUMED Notice 5312 of 16 April 1976.

Revised organization manual for regional dental centers

The Naval Regional Dental Center Organization Manual has been revised. Naval regional dental centers shall conform to the organization plan detailed in BUMED Instruction 5450.143 of 13 April 1976, and shall submit revised regional organization manuals to BUMED Code 6 by 31 October 1976. Branch dental clinics shall follow the same plan, with appropriate modifications and alignment with their assigned regional dental center.

Notes & Announcements

NURSING COURSES SET FOR NRMC PORTSMOUTH

The following courses for Navy nurses and paramedical nursing personnel will be given at Naval Regional Medical Center Portsmouth, Virginia in 1976 and 1977. For further information contact LCDR Shirlee C. Hicks, NC, USN, educational coordinator, Naval Regional Medical Center, Portsmouth, Virginia 23708.

1976	
2-20 Aug	Coronary care workshop for nurses
20 Sep-1 Oct	Critical care workshop for nurses
22 Oct	Third annual nursing symposium "Dimensions in Communications"
1-19 Nov	Coronary care workshop for paramedical nursing service personnel
29 Nov-3 Dec	Critical care workshop for paramedical nursing service personnel
1977	
31 Jan-18 Feb	Coronary care workshop for nurses
21 Mar-1 Apr	Critical care workshop for nurses
2-20 May	Coronary care workshop for paramedical nursing service personnel
6-10 Jun	Critical care workshop for paramedical nursing service personnel

INDEPENDENT DUTY COURSE REVAMPED

A new curriculum for independent duty hospital corpsmen, emphasizing clinical and operational medicine, has been implemented at the San Diego, California and Portsmouth, Virginia Hospital Corps Schools. Introduced for classes which convened in April and May 1976, the new training provides skills required for both independent and hospital clinical duty.

Revised criteria for assigning graduates to Naval Enlisted Classification 8425 (independent duty), and NEC assignment of personnel trained under the old medical services technician course will be announced later.

The new curriculum runs 40 weeks. Trainees incur 48 months of obligated service starting on the class convening date. Prerequisites for selection are similar to those for the old medical services technician course, although there is greater emphasis on choosing mature personnel, preferably in pay grades E-6 and E-7, with more than six years of naval service. Outstanding E-5 personnel also will be considered.

U.S. Navy Medicine

ONE-ARM DOVE HUNT SET

The Annual One-Arm Dove Hunt will be held in Olney, Texas, 3-4 September 1976. Open to any hand or arm amputee, activities will include a cow chip chunk'n contest, football, golf, a fish fry, a dove dinner, and a variety of social events. For more information contact: One-Arm Dove Hunt Association, PO Box 582, Olney, Texas 76374.

LENGTH OF PATIENT STAY

Length of patient stay (LOPS) in Navy medical facilities has received increased attention since the Department of Defense reduced to 15 days the funded average length of stay for active-duty personnel. Also, LOPS is an important part of the patient care audit and utilization review functions of the medical care evaluation required by the Joint Commission on Accreditation of Hospitals, and outlined in BUMEDINST 6320.54.

Considerable progress has been made, especially since the establishment of medical holding companies. The efforts of Medical Department activities to shorten LOPS through better management have been outstanding. All involved are to be commended. The ALOPS for active-duty personnel through April 1976 is shown in Table I.

Commands should continue to monitor LOPS to assure acceptable averages, and should send innovative ideas for reducing LOPS to BUMED, Code 72.

TABLE I. Average Length of Patient Stay—Active Duty

	1975 JUL	AUG	SEP	OCT	NOV	DEC	1976 JAN	FEB	MAR	APR
WORLDWIDE TOTAL	17.8	14.7	13.3	14.1	13.5	11.1	10.8	10.0	10.1	10.7
United States Total	18.6	15.2	13.7	14.6	13.7	12.1	11.0	10.1	10.4	10.9
ANNAPOLIS	9.5	5.5	4.3	3.9	2.7	4.3	6.4	2.6	2.4	3.5
BEAUFORT	11.4	8.9	12.1	9.9	11.3	8.0	14.0	9.0	11.0	14.0*
BRETHESDA	27.6	28.9	30.4	28.2	22.7	23.4	15.0	11.6	10.3	10.6
BRENTON	20.3	18.5	17.3	14.7	14.0	12.7	12.6	14.2	11.9	14.1*
CAMP LEJEUNE	15.9	12.8	15.8	14.7	13.5	13.7	13.3	11.9	12.2	10.4
CAMP PENDLETON	18.2	18.4	19.6	15.3	15.8	13.7	13.3	12.7	11.1	12.4
CHARLESTON	19.5	17.4	15.8	8.8	9.4	8.8	7.0	6.0	6.0	6.0
CHERRY POINT	4.9	7.3	10.5	9.6	7.3	8.8	10.5	5.1	8.8	7.4
CORPUS CHRISTI	15.2	10.2	10.0	11.2	10.4	13.3	11.9	11.5	11.5	12.5
GREAT LAKES	14.4	15.4	12.1	14.0	15.9	15.9	14.3	14.6	14.8	15.2
JACKSONVILLE	21.5	20.3	19.0	16.0	14.3	19.4*	15.6	14.3	13.4	14.1*
KEY WEST	8.8	7.2	9.3	6.3	6.8	7.5	7.9	10.7	7.9	7.7
LEMOORE	7.8	11.7	8.9	6.5	5.4	6.3	6.0	5.5	4.2	7.0
LONG BEACH	19.5	11.0	13.1	11.0	9.8	13.0*	11.6	10.2	11.2*	10.2
MEMPHIS	15.2	11.8	12.4	9.8	11.0*	11.7*	7.8	9.1	12.2*	8.8
NEW LONDON	19.0	15.7	12.3	8.2	11.8*	10.6	5.6	9.4	9.5	9.8
NEWPORT	18.3	15.8	18.3	14.0	13.8	22.7*	8.1	7.6	14.6*	14.4*
OAKLAND	23.0	19.6	20.4	19.2	17.9	21.2	16.6	14.8	14.6	13.2
ORLANDO	11.4	8.5	13.0	12.1	9.5	10.7	13.7*	10.7	10.7	11.6*
PATUXENT RIVER	4.6	4.5	6.0	2.5	5.4	1.8	3.3	5.9	3.5	4.1
PENSACOLA	15.7	21.1	13.7	14.3	14.2	13.2	13.2	8.6	16.1*	9.6
PHILADELPHIA	36.6	24.7	28.7	27.2	24.9	18.6	24.5	24.0	24.9	23.1*
PORT HUENEME	5.7	9.6	6.0	7.3	5.0	6.0	8.9	6.1	7.5	7.3
PORTSMOUTH	20.2	22.1	20.0	15.9	15.9	16.8	14.5	15.2	13.0	13.5
QUANTICO	6.6	7.7	8.8	11.5*	4.2	11.4*	7.9	7.0	8.3	10.3
SAN DIEGO	32.3	20.8	14.2	11.5	11.4	9.6	8.1	11.8*	7.8	10.6*
WHIDBEY ISLAND	6.0	4.6	3.9	3.2	5.1	4.5	5.6	2.9	4.9	6.0
OUTUS TOTAL	11.4	10.3	10.0	10.3	11.8	10.2	10.6	10.0	9.9	10.0
GUAM	9.4	8.1	9.3	7.9	11.3	8.3	12.7	3.9	9.8	
GUANTANAMO BAY	10.7	7.0	5.0	7.8	10.4	9.5	6.3	10.6	6.0	8.2
NAPLES	10.0	11.8	9.0	10.7	13.1	10.2	10.6	9.9	10.4	10.9
ROOSEVELT ROADS	10.5	11.3	15.9	8.8	10.2	8.4	9.4	8.6	10.7	12.1*
ROTA	6.2	4.3	4.6	4.5	4.4	1.5	2.0	2.8	4.1	3.7
SUBIC BAY	11.0	11.7	9.8	10.8	9.8	14.5*	12.5	11.4	10.8	
TAIPEI	4.6	3.3	8.7	4.6	3.0	4.0	3.9	1.0	8.0	5.0
YOKOSUKA	18.8	18.0	16.3	16.3	19.2*	15.1*	16.8	18.4*	20.1*	19.8*

*Long-term patients discharged

PROFESSIONAL MILITARY COMPTROLLER COURSE SCHEDULE ANNOUNCED

An eight-week, triservice Professional Military Comptroller Course (PMCC) is sponsored four times a year by the Air University, Maxwell Air Force Base, Montgomery, Alabama. The course helps financial managers broaden their understanding of financial management in the Department of Defense.

OPNAVNOTE 5300 of 11 May 1976 announced the following class schedule for 1976 and 1977:

Class	Begins	Ends	Nomination Deadline
76D	26 Oct 1976	17 Dec 1976	23 Aug 1976
77A	18 Jan 1977	11 Mar 1977	30 Nov 1976
77B	19 Apr 1977	10 Jun 1977	14 Feb 1977

These courses are valuable for all mid-level financial managers, military and civilian, and are open to all DOD nominees, 0-3/GS-11 and above. BUMED letter BUMED:461:arh 5300-2 of 27 May 1976 promulgated class quotas, application instructions, and a detailed description of the course.

ORAL SURGERY SYMPOSIUM HELD

A symposium on surgical correction of maxillary and midfacial deformities was held at Naval Regional Medical Center Oakland, California on 21 February 1976. Attending were oral surgery staff members and residents of Letterman Army Hospital, David Grant USAF Medical Center, Highland General Hospital and the University of California at San Francisco, and other civilian orthodontists and oral surgeons from northern California.

Reviewing preoperative evaluation of the orthognathic patient, it was emphasized that the deformity must be properly diagnosed before any surgical procedure is considered; a step-by-step procedure for accumulating such diagnostic data was presented. Unitooth ostectomies for spaced or malpositioned teeth, and the more conventional subapical ostectomies to reposition a poorly positioned anterior maxilla were among the techniques presented. Maxillary ostectomy techniques, it was suggested, should be considered for preserving alveolar bone in the realignment of edentulous ridges.

Diagnosis and treatment of deformities involving hypoplastic bones of the middle face were also discussed. Case presentations demonstrated mobilization, advancement and grafting of the maxilla and upper face. Postoperative complications of the techniques were also discussed.

Dental officer speakers from NRMCO Oakland included CAPT T.W. McKean, CDR J.L. Burk, Jr., and LCDRs R.F. Provencher, S.G. Graff and J.R. Anderson.

CLINICAL SYMPOSIUM HELD FOR INDEPENDENT DUTY CORPSMEN

The independent duty corpsman's need to update his skills was emphasized when some 90 senior hospital corpsmen—75% of them from the fleet—participated in an Independent Duty Corpsmen Symposium at Naval Regional Medical Center San Diego 3-7 May 1976.

Specialists in ophthalmology, surgery, internal medicine, cardiac-thoracic surgery, neurosurgery, urology, otolaryngology, dermatology, psychiatry and dentistry discussed the latest advances in their field—advances corpsmen can use to help patients. Among the topics discussed: nontraumatic surgical emergencies of the abdomen, management of multiple injuries, cardiovascular emergencies, arrhythmias, cardiovascular accidents, drug overdoses, and common psychiatric illnesses. Cardiopulmonary resuscitation was demonstrated by the emergency medical technician training staff of the aviation physiology training unit, Miramar Naval Air Station.

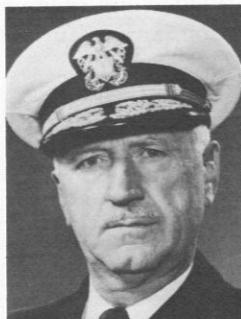
ALCOHOLISM COURSE GIVES CREDIT

"Alcoholism Orientation for Medical Officers," a training course given at Naval Regional Medical Center Long Beach, California, has been approved for 71 hours of Category I continuing medical education credit towards the Physician Recognition Award. Medical officers who have completed the two-week course may request verification that they attended from the Alcohol Rehabilitation Service, NRMHC Long Beach, California 90822.

IN MEMORIAM

VADM Thomas Franklin Cooper, MC, USN (Ret.), who held many key positions in the Medical Department during his 35-year Navy career, died on 3 June 1976 at age 77.

Born on a farm in Johnson County, Missouri on 28 May 1899, VADM Cooper received his bachelor of arts degree in 1922 from the University of Missouri at Columbia, and his M.D. from Jefferson Medical College, Philadelphia, Pennsylvania in 1924. He was commissioned a LTJG assistant surgeon in the Navy Medical Corps in 1924, interned at Naval Hospital San Diego, California, and subsequently served in many naval ships, hospitals, and dispensaries. During World War II, as senior medical officer of the USS *Atlanta*, he won a Bronze Star with Combat "V" and a Presidential Unit Citation for heroic service when his ship was sunk by Japanese forces off Guadalcanal.



VADM T.F. Cooper (MC)
1899-1976

Promoted to CAPT in 1942, VADM Cooper was force medical officer for Commander Service Force, Pacific Fleet (1945-47), commanding officer of Naval Medical Supply Depot, Oakland, California (1947-48), and executive officer of Naval Hospital Philadelphia (1948-50). He commanded Naval Hospital Great Lakes, Illinois from 1950 to 1952, when he was appointed medical officer for the First Naval District and selected for RADM rank. In July 1953 Dr. Cooper became assistant chief for planning and logistics at the Bureau of Medicine and Surgery, and in 1955 was appointed Medical Department inspector general.

Dr. Cooper held command of National Naval Medical Center from 1956 until he retired in 1959, at which time he was advanced to the rank of VADM based on his combat awards. He joined the medical department staff of the Pennsylvania Railroad, now Conrail, following his Navy retirement.

A Fellow of the American Medical Association, and Fellow and Governor of the American College of Surgeons, VADM Cooper was a member of Alpha Kappa Kappa medical fraternity, the Military Order of the World Wars, and the Association of Military Surgeons of the United States. He held the Bronze Star Medal with Combat "V," the Presidential Unit Citation ribbon, WWI and WWII Victory Medals, American Defense Service Medal, American Campaign Medal, Asiatic-Pacific Campaign Medal with five stars, and the National Defense Service Medal.

LCDR Newton W. Parke, HC, USN (Ret.), a Navy pharmacist who served in both world wars, died on 26 April 1976 at age 96.

Born in Brook, Indiana in 1880, Mr. Parke taught high school there before enlisting as a Navy landsman on 5 January 1900. During a training cruise to the Philippines in the USS *Dixie*, his rate was changed to hospitalman apprentice; he then served in the USS *Isla de Cuba* until 1902.

After graduating from Hospital Corps training school in Norfolk, Virginia in 1905, Mr. Parke studied pharmacy on his own time at Milton Academy, Baltimore, Maryland, and rose through the ranks from hospital steward to chief pharmacist. He retired as a LT in 1938, but was called out of retirement at the beginning of World War II; he attained the rank of LCDR before retiring a second time in 1945.

LCDR Parke's duty assignments included naval hospitals in many parts of the United States as well as Puerto Rico and the Republic of the Philippines, the hospital ship USS *Comfort* and seven other Navy ships, and the Potomac River Naval Command during World War II.



LCDR N.W. Parke
1880-1976

AMERICAN BOARD CERTIFICATIONS

American Academy of Family Physicians

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LCDR Frances F.H. Hicks, MC, USNR
LCDR William G. Lowell, MC, USN
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CDR Arthur R. Vernino, DC, USN

American Board of Preventive Medicine (General)

CDR John W. Poundstone, MC, USN
LCDR Richard R. Hooper, MC, USNR

*American Board of Prosthodontics**

CDR John S. Ostrowski, DC, USN

American Board of Psychiatry and Neurology

CDR Richard B. Stice, MC, USN

American Board of Radiology (Diagnostic Radiology)

LCDR William H. Johnson, MC, USNR
LCDR Harry Rosenkrantz, MC, USNR
LCDR Eugene C. Wasson III, MC, USNR

American Board of Surgery

LCDR Paul J. Kovalcik, MC, USNR

American Board of Urology

CDR Tommy S. Kent, MC, USN

*Boards recognized by the American Dental Association

Conservative Removal of Root Fragments from the Maxillary Sinus

LCDR John J. Keller, DC, USN
CAPT Eugene J. Messer, DC, USN
CDR Thomas E. Bollinger, DC, USN

Any dentist who performs routine exodontia must be constantly aware of the maxillary sinus, or antrum. Radiographic examination is indispensable in determining the relationship of the antrum to adjacent anatomical structures, since these relationships vary considerably from patient to patient. The sinus floor may be relatively thick and smooth, or it may be a paper-thin lamina of bone molded over the root apices as they protrude into the sinus cavity (1). Statistically, the tooth most likely to be intimately associated with the antral floor is the first molar, followed in order of frequency by the second molar, second premolar, third molar, first premolar and, rarely, the canine (2).

Even when the dentist uses good surgical technique, root fracture may occur. If he then attempts to remove the root fragment, it may suddenly disappear from the operative field. The dentist who has never seen this happen may be disturbed when he realizes he has transposed a root tip into the sinus.

Many techniques for removing root fragments from the maxillary sinus have been described in the literature, although a number of these techniques have been abandoned (3,4). The classic technique for removing root fragments is first to close the extraction site, and then to remove the fragment through a

Caldwell-Luc approach (5,6,7). But this is not an innocuous procedure; we feel it should be reserved for removing larger root fragments, teeth, or foreign bodies which cannot be removed using the simple technique we describe below.

The technique we advocate is designed for removing only roots and root fragments, not teeth or larger foreign bodies. Most authorities recommend that the procedure be performed immediately after the fragment enters the sinus (8). If the fragment cannot be easily removed with a small suction tip, the dentist presses with his fingers to occlude the patient's nares while the patient blows through his nose. The presence of an iatrogenic opening as well as an unobstructed natural sinus ostium is confirmed if air comes from the iatrogenic sinus opening as the patient blows gently. A radiograph is then taken to ascertain the root fragment's location (Figure 1), and the extracted tooth examined to estimate the fragment's size. The iatrogenic opening is enlarged, if necessary, to accommodate the largest anticipated size of the fragment.

The patient sits upright with the base of his maxillary sinus parallel to the floor. The tip of a bulb syringe filled with saline at body temperature is inserted into the iatrogenic sinus opening (Figure 2). The saline is injected rapidly, creating turbulence throughout the sinus and suspending the root fragment in the solution. Then the nares are occluded, and the patient blows through his nose while his mouth is open. Air enters through the normal sinus ostium (on the lateral nasal wall, in the middle

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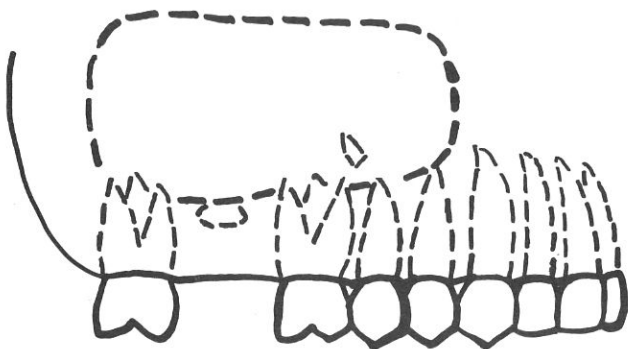


FIGURE 1. Radiographic examination shows location of root fragment.

meatus) and forces the saline out through the opening where the root fragment entered the floor of the maxillary sinus. An emesis basin held below the patient's chin collects the expelled saline and the root fragment, which makes a characteristic "ping" when it strikes the basin (Figure 3).

After the fragment is removed, the mucosa overlying the opening is advanced and closed primarily. The patient is placed on antibiotics, decongestants, and anodyne medications. The anatomical relationship of the nose, maxillary sinus, and oral cavity is discussed with the patient, who is instructed not to smoke or blow his nose, and to keep his mouth open when sneezing or coughing to equalize air pressure in the sinus. The sutures are removed five to seven days after the procedure, when the oral-antral communication is normally healed.

The major possible complication of this technique is the creation of an oral-antral fistula; however, in the 60 cases where we used this technique, we saw no such complication. If the dentist uses proper surgical technique and the patient follows postoperative instructions, healing is usually uneventful.

General dentists unfamiliar with the Caldwell-Luc approach usually cannot remove a fractured root when it is displaced. Retrograde infection may well occur before the patient sees a specialist, decreasing the chance for a successful closure. Our procedure is conservative, well within the ability of any general dentist who routinely extracts teeth, and is our treatment of choice when small root fragments are displaced into the maxillary sinus. In most cases, this procedure eliminates the need for more extensive surgery. Patient acceptance of our procedure is good, and there is reduced postoperative morbidity. Since the procedure is undertaken immediately after the root fragment is displaced, the maxillary sinus is still healthy, an important consideration for any attempt at surgical repair.

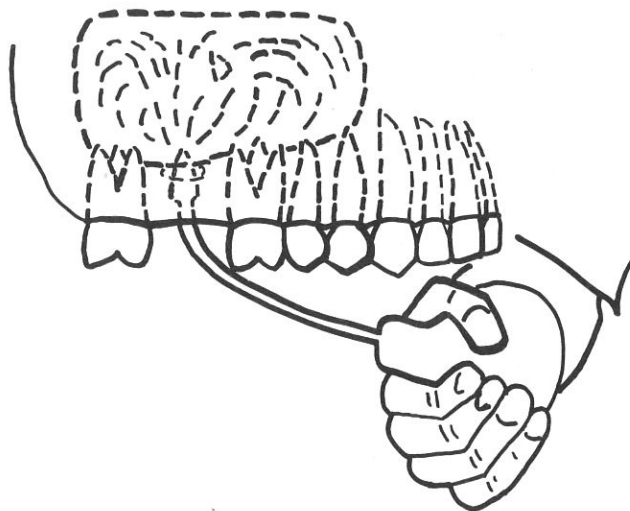


FIGURE 2. Rapid injection of saline creates turbulence, causing suspension of fragment.

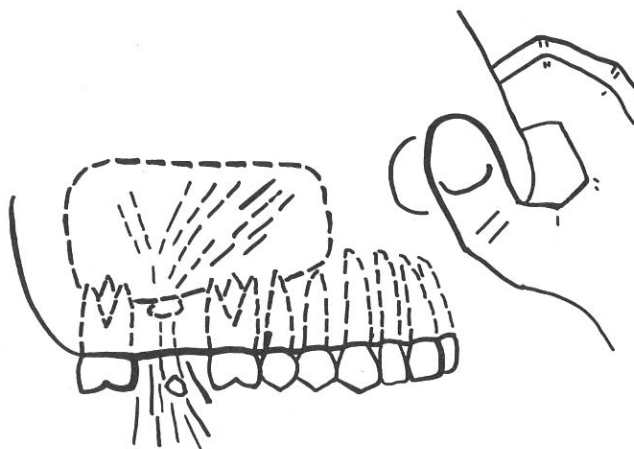


FIGURE 3. While his nares are occluded, the patient blows his nose, forcing air into the sinus through its natural ostium. This pressure forces the saline and suspended root fragment out the iatrogenic opening in the sinus floor.

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Features

Drink, Doctors, and Seadogs

CAPT R.W. Steyn, MC, USN

Seafarers have tolerated alcohol consumption in large quantities since time immemorial, perhaps to face cold, heat, dampness, danger, rigid discipline, heterosexual deprivation, geographic dislocation, and meager sailor's pay, as well as their inner restlessness. Alcohol softens, blurs, distorts, and ultimately obliterates the awareness of these and other realities.

The distillation of alcohol is credited to Jabir ibn Hayyan, an Arab alchemist of the late 8th century, whose name survives in our term *gibberish*. The Dutch seafarers of the West Indies Company settling New Amsterdam built one of the first distilleries in North America around 1640 on Staten Island to manufacture aqua vitae and gin. Along with other Dutch possessions in North America, the distillery passed to the British in 1664, who converted it to the distillation of rum.

In centuries past, warships often carried more alcohol than water. Admiral Edward Vernon, known throughout the English Fleet as "Old Grog," directed the issue of a daily half pint of rum mixed with a quart of water to sailors of the West Indies Fleet on 14 August 1740 to remedy abuses of rum drinking. The mixture, called "grog," proved popular with sailors and won general acceptance in the British Navy.

The American Navy, patterned on the British, incorporated the rum ration by Act of Congress on 27 March 1794, reaffirmed 1 July 1797. The American Temperance Movement also arose around the time of the Revolution. Dr. Benjamin Rush, a signer of the Declaration of Independence, published his "Inquiry

into the Effects of Spirituous Liquors on the Human Body and Mind" in 1784.

In 1806, the American Navy substituted whiskey for rum, as being cheaper and more wholesome. The grog ration, even though a measly half pint a day, was blamed for all the problems associated with injudicious drinking. Most floggings (some say 80%) were inflicted for drunkenness and other transgressions associated with alcohol consumption. The problems arose from sailors saving their rations until they had enough for a blast, and from abstinent sailors selling their rations to drinkers. Gradually, sailors could accept a cash allowance of the magnitude of about a nickel a day or a dollar a month as substitute for their grog ration. The captain could stop a sailor's grog for a period of time as punishment for minor offenses, but if the culprit was receiving money in lieu of spirits, there might be no alternative to flogging. Hence, many sailors continued to draw their grog ration as a kind of insurance against being flogged at some time in the future for an infraction.

In 1829, three naval surgeons reported to the Secretary of the Navy that the spirit ration was unnecessary, harmful to morals and health, and detrimental to rational discipline. They suggested that tea or coffee might be substituted, but conceded that many old sailors would not submit to the abolition of the spirit ration. Yet, under constant Temperance Movement prodding, the Navy halved the spirit ration in 1842, substituting tea, coffee, cocoa, sugar, pickles, and other staples. Moreover, sailors under 21 were no longer permitted to draw the ration.

By 1842, the word *temperance* had become a euphemism for abstinence, and efforts to repeal the grog issue escalated. Dr. William M. Wood, surgeon of the U.S. Navy, argued in a pamphlet entitled "Practical Reflections upon the Grog Ration of the U.S. Navy" that the ration made the men irritable, promoted insecurity, was physically harmful to

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This paper was adapted from CAPT Steyn's presentation at the Conference on Alcoholism conducted for Navy medical officers in February 1976 by the Institute of Pennsylvania Hospital under the auspices of the Bureau of Naval Personnel.

them, and was directly or indirectly responsible for the diseases that placed "chronic invalids" in hospitals at government expense. Moreover, the ration was inconvenient and uneconomical, and the 3,000 gallons of whiskey in the spirit room of a frigate constituted a fire hazard.

After two generations of acrimonious argumentation and political maneuvering, President Abraham Lincoln signed the law abolishing the grog ration, effective 1 September 1862. Along with the abolition of flogging and the establishment of finer recruitment practices, this measure led to a "new" Navy. It might have reduced, but certainly did not eliminate alcohol abuse in the fleet.

THE DRUNKEN SAILOR

For over half of the sailors and Marines who choose to drink, alcohol enriches life without harm and is consumed in moderation. But a large minority abuse alcohol periodically with some damage to themselves and others—the well known brawls of the "drunken sailor." After these periodic intoxications, the physician mends lacerations, dislocations and fractures, and prescribes. The hangovers—often disguised as chief complaints of fatigue, dizziness, nausea, gas, flu, nervousness, and headache—are diagnosed on the record as only the chief complaint out of naivety, haste, helplessness, or not-so-inadvertent ignorance.

These "drunken sailors" depend not so much on alcohol, as on what alcohol represents to them. In some subcultures, drinking symbolizes good fellowship and virility—the rough, manly image. And an image it almost literally is, a perception without substance. A man chooses a challenging, hazardous occupation—sailor. He acquires tattoos to proclaim his toughness and his conflicts to the world. He smokes heavily, drinks coffee and alcohol immoderately, shuns tea, fights on little or no provocation, and fornicates haphazardly.

He adopts this view of adult masculinity probably in the first years of life, grows up emotionally stunted, resists maturation, risks progression towards frank alcoholism, and likely transmits alcoholism to his children. In addition to this common pre-alcoholic sailor type, there are also schizoid, depressed, manic, and normal pre-alcoholic problem drinkers.

About half of these "problem drinkers"—we don't know which half—progress to alcoholism: i.e., drinking alcohol in ways different from ordinary social use, drinking when it is important not to drink,

solitary drinking, drinking before breakfast, drinking in preference to eating, drinking industrial alcohol that contains compounds like antifreeze. This behavior leads to habituation, dependence, addiction with denial, tolerance formation, withdrawal symptoms, and a downhill course with damage to and ultimately loss of reputation, career, money, family, and health.

This pattern evolves in more than 10% of the drinking sailors—let us say some 50,000 to 60,000 sailors and Marines. Surprisingly enough, the great majority of these alcoholics go unrecognized for years despite subtle hints of their problem—absenteeism, long lunch hours, odor of alcohol on breath, and frequent trips to water fountain and bathroom. Among enlisted personnel, the highest rates of alcoholism occur in the administrative-clerical, deck, and construction groups; the lowest rates occur in the technical jobs.

Of these alcoholics, some can simply quit drinking on their own. But these individuals are rare. Most head downhill rapidly between age 35 and 50 via alcohol-associated accidents, crimes, and sickness. Mortality of alcoholics in Navy hospitals amounts to 15/1000 per year compared with overall Navy rates of 2/1000 and Marine rates of 10/1000.

On this course, doctors are frequently used to dispense drugs against ulcers, cirrhosis, impotence, paranoid states, and delirium potatorum. Physicians diagnose the physical condition correctly, and see the alcoholic's outlandish behavior as stemming from a poisoned brain, depression, anxiety, situational reaction, or encephalopathy—preferably not alcoholism (lest it enrage the patient, damage his career, or curtail his retirement benefits). The alcoholic often calls again, with esophageal varices, subdural hematoma, and broken bones.

Many physicians dislike treating alcoholics. Alcoholics often insist on being seen at once, even in the middle of the night. They want tranquilizers, sleeping pills, and emergency vitamin shots to come off a drunk. They don't keep their appointments. They continue to drink and get sick. Problem drinkers evoke hostility instead of compassion. Nevertheless, physicians who ignore the therapeutic nihilism and induce an alcoholic to achieve sobriety find it a real thrill to see him recover, and enjoy supporting recovered alcoholics.

Many of our former alcoholic senior line officers who now manage aspects of the Navy's Alcoholism Prevention Program achieved sobriety through the ministrations of competent, compassionate physicians before the existence of any formal programs.

Those physicians learned from experience that Alcoholics Anonymous and group interactions with other former alcoholics helped alcoholics function and maintain their sobriety. This evangelical group approach pleases patients more than traditional psychotherapy or chemotherapy, and leads not only to longer sobriety, but to a heightened enjoyment of life.

THE PHYSICIAN'S INVOLVEMENT

The notion that alcoholism is an illness goes back at least to the 3rd century, when Roman jurist Domitius Ulpianus suggested that inveterate drunkenness should be a medical rather than a legal issue, and to the 13th century when James I, King of Aragon legislated hospitalization for conspicuously diligent drunkards. The more recent designation of alcoholism as a disease by the World Health Association, the American Medical Association, the American Hospital Association, the American Psychiatric Association, and others is readily accepted both by alcoholics, who liken their impulsive and compulsive drinking to an allergy (which it is not), and by public agencies who realize the futility of treating alcoholism as a sin, a vice, or a crime.

Alcoholism differs from other ailments in many respects. Other maladies, like pneumonia or broken bones, have not required an official designation of disease by professional organizations, and are not as readily denied by the victim. The Navy line provides seminars on alcoholism for medical officers; there are no similar seminars for other common chronic ailments like epilepsy, diabetes, or schizophrenia.

The Navy's Alcohol Rehabilitation Program has demonstrated the feasibility of bringing great numbers of alcoholics to sobriety indefinitely. The medical officer has played an indispensable role in the recognition and rehabilitation of alcoholics. Yet, while alcoholic patients infiltrate all specialty services (even pediatrics), medical officers have by and large shunned involvement in the recognition and rehabilitation of alcoholics. This lack of involvement is a result of training, tradition, and transference.

Training. Until recently, few medical scientists considered alcoholism an academically worthy subject. Medical schools used to teach about the severe maladies associated with alcohol, like esophageal varices, but little about alcoholism itself, even though one-third of patients with delirium tremens are dead within five years. Without readily tangible or visible physical signs or measurable

laboratory findings, the diagnosis of alcoholism rests solely on:

(1) A chief complaint, which is rarely "I drink too much."

(2) The patient's history (rarely honest and not always skillfully elicited).

(3) The informant's history (always suspect of being tainted with hostility).

(4) The longitudinal course of the condition.

To establish a diagnosis, the physician has to elicit, unhurriedly, a shrewd history, an associative anamnesis, rather than the complete, mechanical, questionnaire-type, standard recording of present illness, past history, and review of systems. It is useless to ask the alcoholic why he drinks. He does not know, and will give you—and himself—a rationalization instead of a reason. Better inquire about the "how," "when," "what" of his job, his family life, his hopes, and his fears.

Tradition. The concept of free will embedded in our theology and law allows the individual, when the occasion arises, the option to abstain, drink responsibly, or drink recklessly. Those who elect to drink recklessly, with associated harm to self or others, have therefore been counted among the moral transgressors or the social deviants. Neither religious penitence nor legal penalties effectively modified such a drinker's pattern or irresponsible imbibition. Some taint of sin or crime still sticks to the alcoholic. The contempt directed at the alcoholic may make the caretaker feel better in a glow of self-righteousness, but it makes the alcoholic feel worse. His bothersome feeling of guilt, shame, helplessness, fear, and rage, he promptly resolves and dissolves in more alcohol, recklessly consumed.

Transference refers to some aspects of the doctor-patient relationship. We try to exclude our own morality and sense of beauty from the care of patients—even those with particularly repugnant ailments, even those whose sickness or injury results from their own fault, even those devoid of decency. Nearly all illness is unattractive, and not infrequently patients are ugly in appearance or personality, either intrinsically or following changes brought about by their illness. Somehow, many physicians cannot view alcoholism as an illness, but see it only as a deeply entrenched bad habit, impervious to medical ministrations. Hence, it becomes difficult to muster the extra kindness we have to bestow on patients if we are to succeed in therapy.

Alcoholics often manifest a streak of rebelliousness against authority, which may reflect their great need for dependency, and their resentment and

denial of this need. The physician, particularly the younger one and perhaps even more the military physician, is often imbued with feelings of omnipotence. These the rebellious alcoholic readily thwarts by getting drunk over and over again, depriving the physician of the pleasure of gratitude, respect, and success which he considers his due. Such a relationship is fraught with mutual frustrations.

Another conflict arises over the alcoholic's usual demands for time, of which the physician is always short, and for antacids, decongestants, vitamins, and addicting sedatives. To suggest instead that the origin of the alcoholic's malaise lies elsewhere, and that recovery demands a different attitude towards life or a change in behavior, may tax the physician's time and skill.

Since alcoholism is prevalent in our society, the attitudes of physicians may be colored by their own exposure to alcoholism through alcoholic relatives or friends. Their attitude towards these people—often one of ignoring or denying the problem out of shame, or of overreacting in an emotionally moralistic manner out of self-righteous indignation—may persist to some extent in their dealings with alcoholic patients.

And finally, the number of addicted physicians is significant. An addicted physician is unlikely to diagnose as alcoholic a patient who consumes less intoxicants than the healer.

PROGRAM INGREDIENTS

For decades, a few Navy medical facilities, mainly psychiatric, encouraged Alcoholics Anonymous meetings on the premises. The Navy's organized alcohol rehabilitation effort sprang from an AA meeting of three people held in early 1965 at the Long Beach Dispensary, under the aegis of an energetic, outspoken senior medical officer and a retired commander who had finally achieved sobriety. This venture, later dubbed Drydock Group #1, encountered birth pains and perinatal morbidity, along with lack of recovery of its initial participants and resistance and opposition of line and medical superiors.

By 1967, authorization came for a pilot program: the Alcohol Rehabilitation Center (ARC). Yet for many years, not a single Navy doctor from the nearby hospital ever accepted repeated invitations to visit and see for himself what this group was doing. With the passage of time, and by trial and error, the outfit grew in size, sophistication, and effectiveness to become the prototype of subsequent alcohol rehabilitation centers.

New ARCs of about 75 beds arose under line command in the early 1970's at Norfolk, Great Lakes, San Diego, and Jacksonville. Alcohol Rehabilitation Units (ARUs) of about 15 beds each were grafted onto 15 Navy hospitals. In 1974, the Long Beach facility moved into and became a clinical service of the hospital.

A patient enters the six-week program by asking to go, or being told to go. Alcoholics Anonymous remains a cornerstone of the program. Another cornerstone is the counselor—a former alcoholic, and trained petty officer. Recovering alcoholics first view the physician with suspicion, and the counselor assumes the task of go-between in the development of a trusting relationship. The physician directs the program, supervises the counselor, and takes on the care of the bodily ailments and significant psychiatric impairments.

The ingredients of the program include:

- Time: 6 weeks. An irreducible length of time must elapse in a significant change of life-style. If 20 musicians play a symphony in 90 minutes, 40 musicians cannot play it in 45 minutes.
- Respect and dignity: No locked doors, barred windows, or restraints. Immediate interview upon arrival. This is very important to set the tone.
- Structure: Military setting, uniforms, inspections, and a rigid schedule of activities.
- Communication and peer interaction: Alcoholics Anonymous meetings five evenings a week, group counseling, psychodrama, couples' group, informal rap sessions, with a bent towards conversion from devotion to distilled spirits to a more religious spirituality. The alcoholic soon learns that his sobriety remains his responsibility, not the group's or the physician's.
- Education: Lectures and films on medical, legal, societal, dietary, and mental aspects of alcohol abuse.
- Physical fitness.
- Antabuse, but no other pills except perhaps vitamins. To switch an alcoholic from a liquid to a solid tranquilizer constitutes no accomplishment.
- Periodic assessment of each resident's progress.
- Unfortunately, no work (even though, as Szasz says, "The greatest analgesic, soporific, stimulant, tranquilizer, narcotic, and to some extent, even antibiotic, in short, the closest thing to a genuine panacea known to medical science is work").

This system reaches about 4,500 alcoholics each year—only about 8% of the alcoholics in the Navy and Marine Corps. The restoration-to-duty effectiveness rate hovers around 70%. The waiting list is

long. We don't know the spontaneous remission rate of alcoholism.

To reduce the backlog of patients, some 50 Alcohol Rehabilitation Drydocks have been established consisting of two weeks of residential care followed by 10 weeks of gradually decreasing involvement as an "outpatient" in lectures and groups while the patient continues to work in his unit. There also exists a referral network of 1,500 recovered alcoholics and non-alcoholic physicians, lawyers, and clergymen available to the troubled drinker. Part of this network consists of CODACs (collateral duty alcoholism counselors) who help local commands develop alcoholism prevention and education strategies, and who support the recovered alcoholic when he returns to duty.

WHAT CAN YOU DO?

In dealing with alcoholics, the Navy physician must:

1) Recognize the alcoholism. Active alcoholics are masters at deception and self-deception when it comes to their drinking patterns. Establishment of the diagnosis often requires shrewd detective work, patiently listening for clues, and follow-up on leads. One clue: alcoholics tend to be immoderate in other aspects of their lives, too. This "overindulgence syndrome" may include excessive smoking, coffee drinking, eating, working, sleeping, and use of prescription, over-the-counter, and illegal drugs.

2) Confrontation. This is necessary if the physician hopes to gain the alcoholic's respect. Alcoholics often display a perverted type of humor in which they fool the doctor, laugh at him, yet hurt themselves. Candid communication must be established—a matter-of-fact, tactful, discreet approach shunning callousness, which breeds hostility, and indulgent tolerance, which breeds contempt. Let the patient ventilate. Focus on day-to-day problems with wife, job, money, health, and accentuate the role alcohol plays in creating and perpetuating these problems.

3) Formulate a feasible rehabilitation strategy. (The alcoholic's "Thank you, I see the light. I will stop drinking," is a promise to be broken, not a feasible rehabilitation strategy.)

The physician should not prescribe drugs, except for a few days of withdrawal symptoms, and should not assume responsibility for the alcoholic's sobriety.

As a minimum, a rehabilitation strategy should include periodic, brief, honest, tenacious physician

contact and frequent (several times a week) attendance at AA meetings. (Recovering alcoholics are often terribly thirsty for rigid organization, schedules, orderliness, charts, and so forth, after a drinking pattern that encourages sloth, sloppiness, and slovenliness.) This minimum approach may suffice and be appropriate for dependents, retired personnel, and active-duty people who cannot maintain themselves on the waiting list for an ARU or ARC.

If work with recovered alcoholics gives you professional gratification, you may want to do more. You might try to:

- Involve the family. Helping an alcoholic reach sobriety without involving the family often renders the spouse seriously ill, and you only transfer the malady from one family member to another. Changes in the drinking pattern effect changes in the family equilibrium.
- See your recovered alcoholic patients in groups at least once a week.
- Prescribe Antabuse.
- Use select, mature former alcoholics, solidly sober for a couple of years, as consultants under your supervision.

Physicians without the time or temperament to work with alcoholics need not dabble in alcoholism rehabilitation beyond recognition, confrontation, and referral. The physician's common reluctance to recognize, confront, and refer may stem from many sources, including rejection of the disease model, disinclination to harm the alcoholic's career progress and retirement benefits, and ambivalence between the alcoholic's right to treatment versus his right to refuse treatment. However, it is not necessary to adhere to the disease model: awareness that a public health hazard and preventive medicine issue exists will suffice. On the career and retirement issue, the effects of identification are not invariably deleterious. Many superiors prefer or can be convinced to prefer a sober alcoholic to a drunk alcoholic. Besides, the alternative to recognition, confrontation, and referral usually leads to graver consequences than transfer or delayed promotion.

The issue of the right to receive treatment and the right to refuse treatment, currently prominent in medical circles, implies that the alcoholic who desires sobriety is entitled to the medical expertise to help him toward that goal, and that the alcoholic who desires no help and has committed no crime should be left alone. Involuntary hospitalization is viewed as disguised jailing of the innocent. Some vigilance is necessary lest we move into "the therapeutic state."

A tiny minority of alcoholics ask for rehabilitation completely voluntarily; a more significant portion ask for rehabilitation in response to subtle or gross coercion from relatives, superiors, medical officers, or law enforcers; and a fair number are outright ordered into rehabilitation, often over initial protestations which usually evaporate after a fortnight in the program. There is something to be said for coercion being justified if the taxpayer foots the bill for the accidents, maiming, death of innocents, alcohol-induced illnesses, and lost productivity perpetrated by the alcohol abuser.

Entry into a Navy rehabilitation program should be rather simple, if you don't manage the patient yourself beyond recognition, confrontation, and referral. If your hospital has an alcohol rehabilitation unit, or your area an alcohol rehabilitation drydock, contact the counselor. If not, ask the personnel officer to contact the Armed Services Medical Regulating Office to arrange aeromedical evacuation

to the proper facility.

Finally, some comments about alcoholic physicians in the Navy. They are not rare. They are often skillful healing arts professionals, and very nice people in positions of power. Those characteristics effectively shield them from honest confrontation and proper referral, to the detriment of their patients, their profession's reputation, and their own professional and personal survival. Even if engaged in rehabilitation in a one-to-one doctor-patient relationship, or in an ARU or ARC, a doctor's denial of illness far exceeds the customary denial of other alcoholics. The Alcohol Rehabilitation Service at NRMC Long Beach enjoys the advantage of a medical command, and permits crucial peer interaction among alcoholic physicians and nurses. Many Navy alcoholic physicians have gained sobriety and renewed professional effectiveness after rehabilitation here. Medical officers ought to keep Long Beach in mind for their alcoholic confreres.

Letters

PSYCHOLOGISTS

Your article about Navy Reserve psychologist LT John D. Robinson (MSC) [*US NAV MED* 67(2):21, February 1976], in which you say he is the first black psychologist to serve in the U.S. Navy, was partially in error. I spent two weeks this past March with a LT Lionel Williams (MSC), who is black, and a psychologist, and has been in the Navy Reserve for nine years.

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Clinical Psychologist

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END OF PA TRAINING?

In BUMED SITREP [*US NAV MED* 67(4):14, April 1976] you reported that no more hospital corpsmen will be selected for training as physician's assistants, following a program/budget decision last November that deleted all FY77 PA training billets.

If there will be no training billets open for FY77, will PAs be recruited

from the civilian community? If so, will those with a B.S. degree in health sciences be commissioned as warrant officers?

HM2 L.E. Cheshier, USN
Alameda, California

Selection and training of active-duty hospital corpsmen for the Physician's Assistant Program has been suspended until further notice. If physician's assistant training funds are not restored, it is anticipated that the Navy will begin to recruit enough civilian-trained PAs to sustain a force level of at least 260 Navy physician's assistants. If such action becomes necessary, recruitment of civilian-trained PAs is not envisioned until the end of FY78, when attrition of active-duty warrant officer physician's assistants is expected. Civilian-trained PAs would probably be recruited to the warrant officer level. Qualifications for appointment of civilian-trained PAs will include the minimum requirement that such applicants be graduates of a certified physician's assistant training program.—BUMED Code 312.

NOT O.R. NURSES

Your article about operating room nurses [*US NAV MED* 67(5):20, May 1976], although well written and informative, is illustrated with a misleading picture. The caption accompanying the picture is in error: operating room nurses do *not* administer spinal anesthesia. They give emotional and sometimes physical support to the patient. The photo you printed is of a nurse anesthetist or anesthesiologist administering spinal anesthesia, with the operating room nurse standing in front of the reclining patient.

CAPT Bettye G. Nagy, NC, USN
Head
Professional Nursing Branch
BUMED Code 322

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